PATIENT REGISTRATION

Patient Name _____
Last First Initial

Address _____ City_____ State_____ Zip_____

Home Phone # _____ Cell Phone# _____ Social Security _____-_____-_____

Birth Date____-____-____ Age _____Gender_____ Preferred Language_____ Marital Status ___S___M___D___W

Race_____ Ethnicity_____ Email Address_____

Occupation_____Employer_____Work #_____

Pharmacy: _____

PRIMARY INSURANCE

Insured Name_____ Birth Date_____-_____-_____
Last First Initial

Relation to Insured:___Self___Spouse___Other Primary Care Physician _____

Insurance _____ Policy/ID#_____ Group #_____

Billing Address_____ City_____ State _____ Zip_____

Insurance Phone #_____ Employer _____ Work #_____

SECONDARY INSURANCE

Insured Name_____ Birth Date_____-_____-_____
Last First Initial

Relation to Insured:___Self___Spouse___Other Primary Care Physician _____

Insurance _____ Policy/ID#_____ Group #_____

Billing Address_____ City_____ State _____ Zip_____

Insurance Phone #_____ Employer _____ Work #_____

RESPONSIBLE PARTY

Name _____ Social Security # _____

Address _____City_____ State_____ Zip_____

Relation to Patient _____Self ____Spouse_____Other Phone #_____

EMERGENCY CONTACT

Name_____ Relationship_____ Phone #_____

I hereby authorize payment of Medicare, ALL other insurance benefits to be made directly to Baptist Physician Network for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize to release all information necessary to secure the payment of benefits.

X_____ Date_____
Signature of Patient (or parent if Minor)

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Physician Network
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Performing Sacred Work Everyday

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT PLEASE NOTE: **THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.**

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street

_____
Apartment #

_____
City, State and Zip Code

Type of PHI to be restricted or limited: (Please check all that apply. Note: should you need to be referred to another physician, anything checked will ***NOT*** be shared.)

_____ Home phone #
_____ Home address
_____ Occupation
_____ Name of employer
_____ Visit notes
_____ Hospital notes
_____ Prescription information
_____ Patient History
_____ Office address
_____ Office phone #
_____ Spouse's name
_____ Spouse's office phone #
_____ Other: _____

How may we use and/or disclose of your PHI restricted information?

_____

_____

_____

_____ _____
Signature of Patient or Legal Guardian Date

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize, Baptist Physician Network, to use and/or disclose certain Protected Health Information (PHI) about me to the following family members:

_____

_____

_____

This authorization permits Baptist Physician Network to use and/or disclose medical and/or billing information directly related to my diagnosis and/or treatment. This information will be used or disclosed at the request of myself or the person(s) designated above. This authorization will not expire unless specifically revoked by either myself or the person(s) designated above.

I do not have to sign this authorization in order to receive treatment from Baptist Physician. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Name of Patient or Legal Guardian Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Baptist Physician Network
Patient's Name

Notice of Privacy Practices.

_____ _____
Signature of Patient Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

Last First Middle Initial

Date of Birth: _____-_____-_____ Social Security Number: _____-_____-_____

I request a copy of medical records from _____ (date) to _____ (date)

On the above named patient for the following reason(s):

_____Change in Primary Care Provider

_____Moving or Relocating to another area

_____Other: (please explain) _____

_____

From: _____

Name of Releasing Physician or Facility

Phone: _____ **Fax:** _____

To: _____

Physician, Facility, or Person receiving Records

Phone: _____ **Fax:** _____

_____ _____

Signature of Patient or Authorized Representative Date

I hereby authorize the release of all medical records except notes forwarded by a mental health professional, such as a Psychiatrist, Psychologist, or a Licensed Professional Counselor. I hereby release BAPTIST PHYSICIAN NETWORK from liability associated with this release.

Please complete all fields on this form. Omitted information may cause a delay in your request. 01/16

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New Patient Appointment Cancellation/No Show Policy

Thank you for trusting your medical care to Baptist Physician Network. When you schedule an appointment, with Baptist Physician Network, our desire is to provide you with the highest quality care. This includes making sure that you are provided with an appropriate time and appointment type. Please see our New Patient Appointment Cancellation/No Show Policy below:

- The office will call you to confirm your new patient appointment, one week prior to the appointment. You will also receive an automated call reminder, the week of, or a few days prior to your appointment.
- Any New Patient who fails to show for their initial visit will not be rescheduled.
- Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients, who may be waiting for an appointment.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience these circumstances please contact our office, as soon as you are able, to discuss options that may be available. You may contact our office during our normal business hours with such appointment requests and/or changes. Thank you for understanding and allowing us to care for your medical needs.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) **Relationship to Patient**

_____ _____

Printed Name **Date**

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CONSENT/AUTHORIZATION for TREATMENT

1) I consent to services, treatment and diagnostic procedures, including but not limited to medications and lab test which may be ordered by my provider at BAPTIST Physician Network.

2) I acknowledge full responsibility for the payment of such services and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made. By signing this consent I assign all rights, title and interest and authorize direct payment to the BAPTIST Physician Network of any insurance benefits or benefits under the Social Security Act for the services. BAPTIST Physician Network will assist in billing my insurance company but I am financially responsible for charges not collected by this assignment. I authorize BAPTIST Physician Network to bill my insurance or third party payor and receive payment from them directly.

3) I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, BAPTIST Physician Network may disclose my records to any person, Social Security Administration, insurance or benefit payor, health care service or plan, worker's compensation carrier is, or may be, liable for all or any of the charges. Furthermore BAPTIST Physician Network may disclose my records to other treating providers, health care providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies.

4) My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signed: _____ Date: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____

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Dear valued patient:

The most valuable information that I need to properly take care of you is an accurate medication list. Therefore, I strongly urge you to bring all your MEDICATION BOTTLES with you each time you come for an office visit so we can compare it to our current list and make sure it is accurate. I must have a correct list of your medications, dosage, and the frequency in which you are taking these medications to care for you properly. I also need to be aware of any over-the-counter medications you are taking. As many patients see multiple physicians it is often possible you may be taking medications or had dosage changes that I am not aware of. In addition I request that you call us immediately with any change in your medications or medication dosages. Failure to comply with the above request could lead to serious errors in your treatment with the potential for significant morbidity and mortality. By signing below you attest that you have read and understand the potential seriousness of your noncompliance with this request.

Signature:_____ Date:_____

Baptist
Physician Network
ORTHOPEDIC SPINE CENTER
Performing Sacred Work Every Day

Today's date: _____ **Name:** _____ **Date of Birth:** _____ **Age:** _____
Height: _____ **Weight:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Preferred Pharmacy: _____ **City:** _____ **Phone:** _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

When did the problem start? _day(s) ago _week(s) ago _month(s) ago _year(s) ago

Have you seen another physician for this issue? _No _Yes, who and when? _____

Have you had imaging for this problem? YES NO (XRAYS MRI CT OTHER: _____)

If so, when and where? _____

Have you had an EMG? YES NO Where: _____ When: _____

Have you had Pain Injections? YES NO Where: _____ When: _____
What type: _____

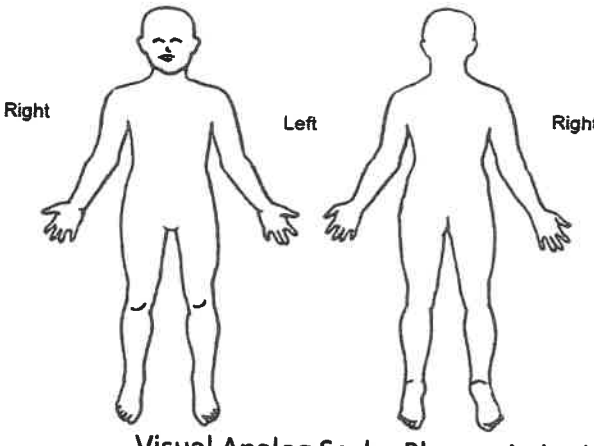
What treatments have you tried in the past? None
___Application of ice ____Application of heat ____Physical Therapy ___Home Exercise ____Massage ____Activity Modification ____Brace
___Acupuncture ____Chiropractic Care ____TENS Unit ____Dry Needling ____NSAIDS ____Other Medication ____Surgical Treatment

What makes your condition feel worse? _____
What makes your condition feel better? _____

SYMPTOM AND PAIN DIAGRAM:

Please be sure to fill this out as accurately as possible. This will become part of your permanent medical record and will be used to compare your progress throughout your treatment. Mark the area on your body where you feel the described sensations(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas.

Sharp/Stabbing Pain (xxx) Dull Ache (000) Numbness (---) Burning (///) Pins and Needles (***) Weakness (+++)



Cervical spine:

What is the RATIO of neck pain vs arm pain?(i.e.,80:20) _____
I have noticed problems with: __Gait/Walking/Balance __Fine Motor Coordination
___Handwriting is sloppier ___Clumsiness, dropping things more frequently.
___Bowel or Bladder incontinence

Lumbar Spine:

What is the ratio of back pain vs leg pain? (i.e.,80:20) _____
I have noticed problems with: __Gait/Walking/Balance _Bowel or Bladder incontinence.

Visual Analog Scale: Please circle the pain levels that most accurately represents your pain.

	0 = NO PAIN									10 = UNBEARABLE PAIN
Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Least Pain	0	1	2	3	4	5	6	7	8	9	10

SOCIAL HISTORY:

Please describe your current tobacco/marijuana use habits:

___Never ___Former (I quit____years ago) ____Current **I use:** _Cigarettes _Vaping _Marijuana _Chew/Dip

Frequency: _Current every day _Light _Heavy

Do you drink alcoholic beverages? ___Yes ____Not Currently _____Never
If yes, what type and how many servings per week: _____

Have you ever used any illicit drugs? _Yes _Not Currently _____Never
If yes, what type of drug and how often: _____

How would you rate your exercise level? _Sedentary _Mild _Moderate _Vigorous
Are you currently working? YES: ____Full time ___Part time ___With restrictions Occupation: _____

NO: I have not worked since_____ ___Disabled ____Retired ___Unemployed

___Homemaker ___Student ___Other: _____

MEDICATIONS:

_____I am not currently taking any medications.

List any medications, vitamins, minerals, supplements, and alternative/herbal medications that you are currently taking:

Name of Medication	**Dose**	**Frequency**

ALLERGY HISTORY:

__**None _NKDA (No Known Drug Allergies)**

Metal Allergies: _No _Yes Agent:_____Reaction: _____
Latex Allergies: _No _Yes Agent:_____Reaction: _____
Medication Allergies: _No _Yes Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
Agent:_____Reaction:_____
IV Contrast Allergies: _No _Yes Agent:_____Reaction:_____
Other Allergies: _No _Yes Agent:_____Reaction:_____
Agent:_____Reaction:_____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___Abnormal EKG
___Anemia
___Anesthesia Complication
___Asthma
___Blood Transfusion
___Cancer:_____
___Cirrhosis
___Clotting Disorder/DVT
___COPD
___Coronary Disease
___Diverticulitis
___Fibromyalgia
___GERD
___GI Bleeding
___Glaucoma
___Gunshot Wound
___Head/Brain Injury
___Hearing Loss
___Heart Failure Diastolic
___Depression/Anxiety
___Diabetes Type I/Type II
___Fracture
___Heart Failure
___Hepatitis
___HIV/AIDS
___Hyperlipidemia
___Hypertension
___Hyper/Hypothyroidism
___Kidney Disease
___Heart Valve Disease
___Hemodialysis
___IBS
___Kidney Stones
___Lupus
___Macular Degeneration
___MVA
___Peripheral Artery Disease
___Peritoneal Dialysis
___Liver Disease
___Myocardial Infarct
___Osteoarthritis
___Osteoporosis
___Pulmonary Hypertension
___Seizures
___Sickle Cell Anemia
___Sleep Apnea
___Stroke/TIA
___Substance Abuse
___Pneumonia
___Restless Leg Syndrome
___Rheumatoid Arthritis
___Sciatica
___Scoliosis
___Tuberculosis
___UTIs
___Vascular Disease
___Vertigo
___Angina
___Arrhythmia
___Arthritis
___Atrial Fibrillation
___Bleeding Disorder
___Cataracts
___Chronic Fatigue
___Chronic Pain
___Colon Polyps
___Disabilities
___Obesity
___Gout
___Lyme Disease
___Alzheimer's Disease
___Multiple Sclerosis
___Parkinson's Disease
___Peripheral Neuropathy
___Difficulty Swallowing
___History of MRSA

Other: _____

_____

PAST SURGICAL HISTORY

_____**None** (Please mark as applicable, date does not need to be exact)

Procedure	Year	Procedure	Year	Procedure	Year
_Achilles Repair	_____	_Arthroscopic Knee – Left	_____	_Amputation	_____
_Ankle Surgery	_____	_Arthroscopic Knee – Right	_____	_Angioplasty	_____
_Thoracic Spine Surgery	_____	_Knee Replacement – Lt	_____	_Appendectomy	_____
_Lumbar Spine Surgery	_____	_Knee Replacement – Rt	_____	_Cardiac Bypass Surgery	_____
_Elbow Surgery	_____	_Meniscus – Left	_____	_Cardiac Pacemaker	_____
_Foot Surgery	_____	_Meniscus – Right	_____	_Cardiac Valve	_____
_Hand Surgery	_____	_Cervical Spine Surgery	_____	_C-Section	_____
_Hip Replacement – Lt	_____	_Rotator Cuff Repair – Lt	_____	_Colostomy/ Colectomy	_____
_Hip Replacement – Rt	_____	_Rotator Cuff Repair – Rt	_____	_Gallbladder	_____
_ACL Repair – Left	_____	_Arthroscopic Shoulder – Lt	_____	_Gastric Bypass	_____
_ACL Repair – Right	_____	_Arthroscopic Shoulder – Rt	_____	_Hernia Repair	_____
_ORIF Fracture – Left	_____	_Carpal Tunnel Surgery – Lt	_____	_Small Bowel	_____
_ORIF Fracture – Right	_____	_Carpal Tunnel Surgery – Rt	_____	_Thyroidectomy	_____

Other:_____

_____

_____

Have you experienced any adverse events associated with surgery or anesthesia?

___No ___Yes, if so, please give pertinent details: _____

_____

FAMILY HISTORY:

___Adopted (Unknown History)

Place an "X" under the correct family member with the condition.

Alcohol/ Substance Abuse					
Anesthetic Complications					
Asthma					
Broken Bones					
Cancer:					
type:					
Clotting Disorder					
Collagen Disease					
Dementia					
Diabetes Type I					
Diabetes Type II					
Dislocations					
Heart Disease					

Hypertension					
High Cholesterol					
Kidney Disease					
Liver Disease					
Lung/Resp Disease					
Mental Illness					
Osteoporosis					
Rheumatologic Disease/Arthritis					
Scoliosis					
Severe Sprains					
Stroke					
Thyroid Problems					
Anxiety/Depression					

Mother Father Sister Brother Child

Mother Father Sister Brother Child

Other:_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____January 1, 2017_____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operation, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established to protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also,

when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

NOTICE OF PRIVACY PRACTICES

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary; to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the time we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.