Dear Patient,

I hope to see you as a new patient in my practice. I would like to be sure that my part time, outpatient Psychiatry and Sleep Medicine practice is compatible with your medical needs. To ensure that I provide the best possible care to each of my patients it is necessary for me to establish certain guidelines. This letter is an effort to make you aware, as a new patient, of my policies and procedures within my practice.

I am unable to see new patients that require controlled pharmaceutical agents. This includes all benzodiazepines, stimulants and opiates. You may want to consult your pharmacist to see if any of your medications fall into these categories. I will be glad to treat you if you do not need any of these types of medications or have been off these medications for at least one month.

My practice does not treat addictive disease and will not see anyone using recreational drugs. Consuming alcoholic beverages impacts how you respond to psychotropic medications. Patients may need to abstain from alcohol as new medication is adjusted. If a patient has completed rehab and would like to be seen for follow up and treatment, I would be glad to consider such patients.

If you have a sleep disorder I will order, schedule, read and discuss your sleep study with you. I will explain the results of your study and prescribe any necessary treatment. However, sleep disorders cannot be managed without the appropriate sleep study.

All new patients must complete the new patient paperwork. This paperwork is available online, through our website, or in our office. Patients may arrive thirty minutes before their scheduled appointment to complete paperwork or bring completed paperwork with them. We must have all completed paperwork before any new patient can be seen for their scheduled appointment.

It is my sincere hope that these guidelines will enable me to provide the best possible care for my patients. I look forward to welcoming you into my practice. Thank you for trusting me to be your doctor.

Sincerely,

Ann B. McDowell M.D.

ANN B. MCDOWELL, M.D.

Dothan Psychiatry and Sleep Disorder Medicine

(334) 791-8015

Please fill out paperwork and bring it with you to your appointment.
If you can't keep your scheduled appointment or if you have any questions please give our office a call at
334-702-7222 Ext. 235
Thank you,

Dr. McDowell's Office

ANN B. MCDOWELL, M.D.

Dothan Psychiatry and Sleep Disorder Medicine

(334) 791-8015

PATIENT INFORMATION:

NAME: _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____

WHAT BRINGS YOU TO THE OFFICE TODAY?

_____

_____

_____

_____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

WHAT EVENTS TOOK PLACE THAT MAY HAVE MADE YOU FEEL LIKE THIS?

_____

_____

_____

_____

HAVE YOU EVER HAD TREATMENT FOR THIS PROBLEM? (Medications, therapy, tests, etc.)

_____

_____

_____

_____

HOW WOULD YOU DESCRIBE YOUR MOOD?

SAD ☐	HAPPY ☐	ANXIOUS ☐	FEARFUL ☐	ANGRY ☐
IRRITABILE ☐	EUPHORIC ☐	OTHER:		

HOW WOULD YOU DESCRIBE YOUR SLEEP?_____

HOW WOULD YOUR DESCRIBE YOU ENERGY?_____

HOW WOULD YOU DESCRIBE YOUR CONCENTRATION?_____

HOW WOULD YOU DESCRIBE YOUR APPETITE?_____

ARE YOU EASILY FRUSTRATED? IF SO, HAS IT BECOME WORSE?_____

HAS YOUR SEXUAL DESIRE CHANGED? INCREASE OR DECREASE?_____

ARE YOU NOW OR HAVE YOU EVER BEEN SUICIDAL?_____

DO YOU HAVE OBSESSSIVE THOUGHTS OR BEHAVIORS?_____

DO YOU EVER FEEL WORTHLESS, HOPELESS, HELPLESS, OR GUILTY?_____

DO YOU EVER FEEL YOU'VE LOST YOUR ABILITY TO FEEL JOY?_____

DO YOU SEE VISIONS OR HEAR VOICES?_____

DO YOU EVER FEEL THAT PEOPLE ARE WATCHING YOU, FOLLOWING YOU, OR WHISPERING ABOUT YOU?_____

MEDICAL DIAGNOSIS AND PROBLEMS:_____

_____

_____

_____

- DO YOU HAVE ANY METAL IMPLANTS?_____
- DO YOU HAVE ANY MEDICAL IMPLANTS?_____
- HAVE YOU EVER HAD A SEIZURE?_____
- HAVE YOU EVER BEEN DIAGNOSISED WITH OBSTRUCTIVE SLEEP APNEA?_____
- ARE YOU ON A SPECIAL DIET?_____

ALLERGIES:_____

_____

_____

_____

PAST SURGERIES:_____

_____

_____

_____

PAST HOSPITALIZATIONS:_____

_____

_____

_____

MEDICATIONS: (please list all medications you are currently taking including how often and dosage)

MEDICATION:	DOSAGE (mg)	HOW MANY TIMES A DAY?	ON FOR HOW LONG?	SIDE EFFECTS?	WHO PRESCRIBES IT?

ALLERGY			**ENT**		
Runny nose	yes ☐	no	Cold	yes ☐	no
Scratchy throat	yes ☐	no	Nose bleeds	yes ☐	no
Itchy eyes	yes ☐	no	Hearing loss	yes ☐	no
Ear fullness	yes ☐	no	Sore thorat	yes ☐	no
Sinus congestion	yes ☐	no	Ringing in the ears	yes ☐	no
RESPIRATORY			Sinus pain	yes ☐	no
Short of breath	yes ☐	no	**FEMALES**		
Chest congestion	yes ☐	no	Menopause	yes ☐	no
Cough	yes ☐	no	Heavy periods	yes ☐	no
CARDIOLOGY			Painful periods	yes ☐	no
Chest pain	yes ☐	no	Breast pain	yes ☐	no
Palpitations	yes ☐	no	Pelvic pain	yes ☐	no
Swelling of the legs	yes ☐	no	**MALES**		
Varicose veins	yes ☐	no	Difficulty with errections	yes ☐	no
CONSTITUTIONAL			Enlarged prostate	yes ☐	no
Weight gain	yes ☐	no	**GASTRO**		
Loss of appetite	yes ☐	no	Nausea	yes ☐	no
Fever	yes ☐	no	Heartburn	yes ☐	no
Weakness	yes ☐	no	Vomiting	yes ☐	no
Weight loss	yes ☐	no	Abdominal pain	yes ☐	no
Fatigue	yes ☐	no	Difficulty swallowing	yes ☐	no
DERMATOLOGY			Diarrhea	yes ☐	no
Rash	yes ☐	no	Constipation	yes ☐	no
Moles	yes ☐	no	**HEMATOLOGY**		
Lumps	yes ☐	no	Swollen glands	yes ☐	no
Dry or sensitive skin	yes ☐	no	Swollen Lymph nodes	yes ☐	no
Hives	yes ☐	no	Easy bruising	yes ☐	no
Skin cancer	yes ☐	no	**MUSCULOSKELETAL**		
ENDOCRINOLOGY			Joint stiffness	yes ☐	no
Excessive thirst	yes ☐	no	Joint pain	yes ☐	no
Cold intolerance	yes ☐	no	Joint swelling	yes ☐	no
Heat intolerance	yes ☐	no	Leg cramps	yes ☐	no
Diabetes	yes ☐	no	Sciatica	yes ☐	no
Hair loss	yes ☐	no	Fracture	yes ☐	no
Goiter	yes ☐	no	**NEUROLOGY**		
Tired/sluggish	yes ☐	no	Headache	yes ☐	no
UROLOGY			Tingling/numbness	yes ☐	no
Difficulty urinating	yes ☐	no	Seizures	yes ☐	no
Frequent urination	yes ☐	no	Dizziness	yes ☐	no
Urinary incontinence	yes ☐	no	Memory loss	yes ☐	no
Recurrent UTI	yes ☐	no	**OPTHALMOLOGY**		
Frequent urination at night	yes ☐	no	Diminished vision	yes ☐	no
Blood in the urine	yes ☐	no	Cataracts	yes ☐	no
			Eye irritation	yes ☐	no

FAMILY HISTORY: (Has anyone in your family ever been treated for any of the following? Please check all that apply.)

	FATHER	MOTHER	AUNT	UNCLE	BROTHER	SISTER	CHILDREN	GRANDPARENT
ANXIETY	☐	☐	☐	☐	☐	☐	☐	☐
DEPRESSION	☐	☐	☐	☐	☐	☐	☐	☐
PANIC	☐	☐	☐	☐	☐	☐	☐	☐
SUICIDAL BEHAVIOR	☐	☐	☐	☐	☐	☐	☐	☐
PSYCHOSIS	☐	☐	☐	☐	☐	☐	☐	☐
SUBSTANCE ABUSE	☐	☐	☐	☐	☐	☐	☐	☐
LOUD SNORING	☐	☐	☐	☐	☐	☐	☐	☐
DAYTIME SLEEPINESS	☐	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	☐	☐

HAVE ANY OF YOUR IMMEDIATE FAMILY MEMBERS (mom, dad, sibling, etc.) EVER TAKEN MEDICATIONS FOR WHAT BRINGS YOU TO US TODAY? IF SO, WHAT MEDICATION AND DID IT WORK WELL FOR THEM?

_____

_____

_____

_____

WHERE WERE YOU BORN?_____

HOW MANY CHILDREN WERE IN YOUR FAMILY?_____WHERE DID YOU RANK IN THE CHILDREN?_____

HOW WOULD YOU DESCRIBE YOUR HOME LIFE AS A CHILD?_____

_____

_____

_____

EDUCATION HISTORY: (High school, college, graduate school, etc. Where did you attend, when did you graduate, and what degrees did you obtain?)_____

_____

_____

_____

JOB HISTORY:

ARE YOU DISABLED?_____ IF SO FOR HOW LONG?_____

ARE YOU RETIRED?_____ IF SO FOR HOW LONG?_____

IF YOU ARE RETIRED, DISABLED, OR UNEMPLOYED: WHAT WAS YOUR LAST JOB AND HOW LONG WERE YOU THERE FOR?_____

_____

CURRENT OCCUPATION:_____

_____

LENGTH OF TIME AT THIS JOB?_____

MARITAL STATUS: (please circle one)

SINGLE☐ MARRIED☐ SEPERATED☐ WIDOWED☐ DIVORCED☐ COHABITING WITH PARTNER☐

PLEASE LIST ANY CURRENT AND PREVIOUS MARRIAGES, WHEN THEY OCCURRED, HOW LONG THEY LASTED, AND WHY IT ENDED?_____

_____

FAMILY COMPOSITION: (Please list all people living in your household)_____

_____

WHAT ACTIVITIES DO YOU ENJOY DOING?_____

_____

_____

RECREATIONAL SUBSTANCES: (Please circle if you do any of the following)

TOBACCO ☐ ALCOHOL ☐ VAPER CIGERETTE ☐ OTHER ☐

IF YOU SMOKE: HOW MANY CIGERETTES A DAY?_____HOW LONG HAVE YOU SMOKED?_____

ARE YOU READY OR THINKING ABOUT QUITTING?_____

IF YOU DRINK: HOW OFTEN DO YOU DRINK?_____

WHAT DO YOU DRINK?_____

HOW MUCH DO YOU DRINK?_____

IF OTHER: PLEASE EXPLAIN_____

_____

_____

SLEEP HISTORY:

DO YOU HAVE ANY PARTICULAR PROBLEMS WITH YOUR SLEEP?_____

_____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

HAVE YOU EVER HAD A SLEEP STUDY? IF SO, WHEN AND BY WHO?_____

_____

_____

WHEN DO YOU GO TO BED? WEEKDAYS_____WEEKENDS_____

HOW LONG DOES IT TAKE YOU TO FALL ASLEEP?_____

WHAT POSITION DO YOU SLEEP IN?_____ HOW MANY PILLOWS DO YOU USE?_____

DO YOU SNORE? _____ HAS ANYONE SAID YOU STOP BREATHING WHEN YOU SLEEP?_____

HOW MANY TIMES DO YOU AWAKE AT NIGHT?_____ ARE YOU ABLE TO EASILY FALL BACK TO SLEEP?_____

WHAT TIME DO YOU WAKE UP?_____IS IT ON YOUR OWN OR WITH AN ALARM?_____

HOW LONG FROM THE TIME YOU WAKE UP UNTIL YOU GET OUT OF BED?_____

HOW LONG DOES IT TAKE FOR YOU TO FEEL ALERT AND AWAKE?_____

UPON WAKING UP DO YOU HAVE ANY OF THE FOLLOWING?

HEADACHES ☐	DRY MOUTH ☐	FEELING GROGGY ☐	SHORT OF BREATH ☐	HEART PALPATATIONS ☐

HAVE YOU HAD ANY WEIGHT CHANGES IN THE PAST YEAR AND IF SO, PLEASE DESCRIBE?_____

_____

_____

_____

DO YOU DRINK CAFFEINATED BEVERAGES (Coke, tea, coffee, etc.), IF SO HOW MANY A DAY?_____

_____

_____

DO YOU NAP DURING THE DAY? IF SO, ABOUT HOW LONG?_____

DO NAPS MAKE YOU FEEL (please circle one): BETTER ☐ WORSE ☐ NO DIFFERENT ☐

WHAT DO YOU DO DURING THE DAY? (if you work please put the hours and number of day a week you work):_____

_____

_____

DO YOU HAVE CONCERNS ABOUT ANYTHING ELSE?_____

_____

_____

_____

The Epworth Sleepiness Scale (ESS)

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO FEELING JUST TIRED? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY TRY TO WORK OUT HOW THEY WOULD HAVE AFFECTED YOU. USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPTAITE NUMBER FOR EACH SITUATION:

0 = WOULD NEVER DOSE

1 = SLIGHT CHANCE OF DOZING

2 = MODERATE CHANCE OF DOZING

3 = HIGH CHANCE OF DOZING

SITUATION:	CHANCE OF DOZING (0-3)
SITTING AND READING	
WATCHING TELEVISION	
SITTING INACTIVE IN A PUBLIC PLACE (e.g. theater or meeting)	
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	
LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT	
SITTING AND TALKING TO SOMEONE	
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	
IN A CAR (you driving), WHILE STOPPED FOR A FEW MINUTES IN TRAFIC	
TOTAL SCORE:	

NOTES:_____

_____

_____

_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Dothan Behavioral Medicine Clinic PATIENT REGISTRATION FORM

(Please Prin

Today's Date: Doctor / Clinician to be seen:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: Age: Sex: ☐ M ☐ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Blue Cross ☐ Cigna ☐ United Healthcare ☐ Aetna ☐ Tricare ☐ Value Options ☐ Medicare ☐ Medicaid ☐ Welfare *(Please provide coupon)* ☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

COLLECTION AGREEMENT

IF YOUR ACCOUNT SHOULD BECOME DELINQUENT MORE THAN 60 DAYS, IT WILL BE TURNED OVER TO A COLLECTION AGENCY. A COLLECTION FEE OF 33% AND 18% INTEREST FEE WILL BE ADDED TO THE BALANCE ON ACCOUNT.

Patient/Guardian signature Date WITNESS DATE

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dothan Behavioral Medicine Clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

CONSENT FOR INTERVENTIONS AND TREATMENT FOR ALL PATIENTS AT A DOTHAN BEHAVIORAL MEDICINE CLINIC

1. MEDICAL CONSENT: You are hereby giving consent for medical treatment and procedures (except for complex procedures which require special consent), including therapy, psychological testing, prescription of medication, urine drug screening, drawing blood for tests, injections, taking photographs, videotaping, laboratory procedures, and other services rendered under the general and special instructions of the attending physicians or other clinicians of Dothan Behavioral Medicine Clinic assisting in your care.

2. REQUIREMENTS: You must tell the doctor and the assessment specialist about your illnesses and medicines and be willing to fill out questionnaires.

3. MEDICATION: Medication treatment, drug selection, and treatment options will be discussed with you if medications will be considered for your treatment. In certain circumstances the attending physician may choose to offer treatment with medications prescribed "off label" meaning that they are not FDA approved for a specific age or condition.

4. RISKS: The medication(s) you and the attending physician choose may cause adverse drug reactions such as: headaches, palpitations, vomiting, tics, severe rash, hallucinations, constipation, dry mouth, cramps, seizures, dizziness, agitation, muscle rigidity, sedation, diarrhea, blurred vision, seizures, trouble sleeping, sinus problems, sweating, feeling hot, muscle pain, numbness of hands and feet, lack of appetite, abnormal movements, mood instability, irritability, or anger.

5. ALLERGIC REACTION: You may experience symptoms of sensitivity or an allergic reaction from medication(s) prescribed. These include rash, hives, and difficulty breathing and swelling of the face. Any of these symptoms may be severe. If you have any of the above symptoms or any other problems, or become pregnant, you must stop the medication immediately, tell the doctor or nurse right away and/or go to an emergency room.

6. WHO TO CALL: If you experience any adverse drug reactions, allergies, sensitivities to medications prescribed at the Dothan Behavioral Medicine Clinic or if you have any questions related to diagnosis or treatment, or if you become a danger to self or others you should contact us at 866-224-2822 (line available day or night, 365 days a year) and/or go to the closest emergency room.

7. THERAPY: You may be offered therapy at DBMC as a treatment option combined or not with medications. You consent with this treatment option if recommended by the attending physician, psychologist or counselor.

8. TESTING: You may be offered psychological testing at DBMC as a procedural option. You consent with this option if recommended by the attending physician, psychologist or counselor.

9. CONSENT: My signature below indicates that I have read the above and had a chance to ask questions to help me understand what my participation as a patient of DBMC will involve and give consent for interventions and treatment.

IF PATIENT IS A MINOR FILL OUT ONLY SECTION B *

** Under current law, this means a single individual under 19 years of age and a married individual less than 18 years of age*

SECTION A

I have read, agreed to and received a copy of this Consent.

_____ _____

Patient's Signature Date

_____

Patient's Name Printed

Signature of Person Obtaining Consent

_____

SECTION B *THE FOLLOWING IS TO BE SIGNED BY LEGAL GUARDIAN ONLY!*

I have read, agreed to and received a copy of this Consent.

_____ _____

Parent or Guardian's Signature Date

_____

Parent or Guardian's Name Printed

_____

Patients Name Printed

Signature of Person Obtaining

Consent_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign this acknowledgement form.

By signing this form I confirm that I have received a copy of the Notice of Privacy Practices.

(Office use only) Case Number: _____

Print Name: _____

Sign Name: _____

Relationship to patient: _____

Date: _____

Written acknowledgement was not obtained

a. **Patient refused to sign**
b. **Emergency situation**
c. **Unable to communicate with patient**
d. **Other** _____

_____ _____

(Witness Signature) (Date)

Note: Future changes in federal and state law may mandate revisions.

Dothan Behavioral Medicine Clinic

No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollars ($25) fee; this will not be covered by your insurance company.

_____ _____ ___/___/___

Print Patient Name **Signature Patient/Guardian** **Date**

Coroners: We may release information to a coroner or medical examiner for identification or to determine the cause of death.
National Security: We may release information about you to authorized officers so they may provide protection to the president, as well as other national security activities authorized by law.

YOUR RIGHTS:

1. You have the right to inspect and request a copy of the health care information that may be used to make decisions about your care. Usually this includes medical and billing records, but may not include psychotherapy notes. To inspect and request a copy of your health care information, you must submit your request in writing to: Dothan Behavioral Medicine Clinic, Attn: Medical Records Department, 408 Healthwest Drive Dothan, AL. 36303. If you request a copy of the information, we will charge a fee for the cost of copying, mailing, or other supplies associated with your request.

2. If you feel that health care information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Clinical/Medical Director. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your the person or entity that created the information is no longer available to make the amendment; (2) Is not part of the health information kept by Dothan Behavioral Medicine Clinic; or (3) Is accurate or complete.

3. You have the right to request an "account disclosure." This is a list of the disclosures we made of health information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Clinical/Medical Director. Your dates may not include dates before April 14, 2003.

4. You have a right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. To request restrictions, you must make your request in writing to the Clinical/Medical Director. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

5. You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. This notice will contain on every page, in the bottom left hand corner, the effective date.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Dothan Behavioral Medicine Clinic. To file a complaint with DBMC, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

PRIVACY OFFICER: Tami Johnson, Chief Privacy Officer, 408 Healthwest Drive Dothan, AL. 36303 334-702-7222

OTHER USES OF HEALTH INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we have provided to you. Dothan Behavioral Medicine Clinic / HIPPA PRIVACY NOTICE: 04142004 FORM 1002-A