PERSONAL MEDICAL HISTORY

Last Name	First	Middle	DOB	Education
Address	City State	Zip	Home Phone	Business
Occupation	Religion		Sex	Marital Status
Date of last physical examination:		Physician:		

Family History		Living		Deceased	
Family Member	Sex	Age	Medical Problems	Age at Death	Cause
Father:					
Mother:					
Siblings:					
Husband/Wife:					
Children:					

Do you know of any blood relative who had or currently has the following?: (circle and give relationship)

Stroke	Heart Attack	Epilepsy
Cancer	Migraine	Suicide
High Blood Pressure	Asthma	Ulcers
Tuberculosis	Allergies	Kidney Disease
Diabetes	Bleeding Tendency	Goiter
Leukemia	Congenital Heart Disease	Arthritis
Rheumatic Heart	Respiratory Disease	Alcoholism
Psychiatric/Emotional Disorders	Hypertension	Osteoporosis

Medical: Please check (x) if you have ever had the following:

	Year		Year		Year		Year
Anemia ( )		DES Exposure ( )		Kidney Disease ( )		TB Skin Test:	
Angina ( )		Diabetes ( )		Knocked Unconscious ( )		Positive ( )	
Arthritis ( )		Diverticulosis ( )		Malaria ( )		Negative ( )	
Asthma ( )		Emphysema ( )		Meningitis ( )		Ulcers ( )	
Back Trouble ( )		Gallstones ( )		Pancreatitis ( )		Tonsils ( )	
Bladder Infection ( )		Glaucoma ( )		Pleurisy ( )		Gallbladder ( )	
Blood Transfusion ( )		Gout ( )		Pneumonia ( )		Ovary ( )	
Bowl Polyp ( )		Hay fever ( )		Polio ( )		Prostate ( )	
Broken Bones ( )		Heart Attack ( )		Radiation Treatment ( )		Hernia ( )	
Bronchitis ( )		Heart Murmur ( )		Rheumatic Fever ( )		Uterus ( )	
Cancer ( )		Hemorrhoids ( )		Seizures ( )		Other ( )	
Cataract ( )		Hepatitis ( )		Sinusitis ( )		Any other serious illness not listed:	
Colo/Sigmoidoscopy ( )		High Blood Pressure ( )		Thyroid Disease ( )			
Appendix ( )		Infectious Mono ( )		Tuberculosis ( )			
Venereal Disease ( )		Jaundice ( )		Exposure to TB ( )			

Continued on next page.

Immunizations:

	Year		Year		Year		Year
Flu Shot ( )		Tetanus ( )		Pneumovax ( )		Other ( ) Name:	

Health Maintenance: Please check (x) if you have ever had the following:

	Year		Year		Year		Year
Chickenpox ( )		Pap Smear ( )		Hemoccult Cards ( )		PSA ( ) ↓	
Mammogram ( )		Colon Cancer Scrn ( )		Prostate Exam ( )		Results:	
Cholesterol Test ( ) ↓							
Results:							

List all medications and nutritional/herbal supplements that you currently take:

Personal Habits: (Circle)

Yes No Do you regularly smoke? What?_____ How much per day?_____

Yes No Do you drink tea, coffee or caffeinated soft drinks? What?_____ How many per day?_____

Yes No Do you regularly consume alcohol? What type?_____ How much per day?_____

Yes No Do you exercise regularly? How?_____

Yes No Do you routinely wear a seatbelt?_____

Yes No Do you routinely wear sunscreen?_____

Are you presently taking any of the following?

Yes No	Aspirin, Bufferin, Anacin	Yes No	Tranquilizers
Yes No	Cough Medicine	Yes No	Weight Reducing Pills
Yes No	Laxatives	Yes No	Sleeping Pills
Yes No	Birth Control Pills	Yes No	Water Pills

To be answered by WOMEN only: (Circle)

Yes No Have you ever had breast lumps? If Yes, when? _____

Yes No Do you do monthly self breast exams?

Yes No Have you ever had bleeding between periods? When?_____

Yes No Do you feel bloated and irritable before your periods?

Yes No Do you experience premenstrual syndrome? Explain_____

Yes No Do you experience difficulty or pain with intercourse? Explain _____

Yes No Did you ever have diabetes in pregnancy? How many pregnancies?_____ How many live children?_____

How many cesarean sections?_____ Miscarriages?_____

Yes No Have you ever had discharge from your nipples? When?_____

Yes No Are you having regular monthly periods? Date of last_____ Duration_____

Yes No Do you have heavy bleeding with your periods? When?_____

Yes No Do you experience hot flashes or night sweats? When?_____

Yes No Are you now or have you ever taken birth control pills? When?_____

Yes No Do you experience a lack of sex drive?

Any complications of pregnancy?_____

Daily calcium intake:_____ From Diet_____ From Supplements_____

Have you recently had or do you now have any of the following: (Circle)

Yes No	Loss of appetite?	Yes No	Sensitivity to heat or cold?
Yes No	Weight loss? Amount:_____	Yes No	Night Sweats?
Yes No	Weight gain? Amount:_____	Yes No	Hair Loss?
Yes No	Vision problems?	Yes No	Depression or nervousness?

Have you recently had or do you have any of the following? (Circle)

Yes No	Nausea or vomiting?	Yes No	Crying spells?
Yes No	Easy bruising?	Yes No	Memory loss?

Continued on next page.

Have you recently had or do you have any of the following? (Circle)

Yes No Do you frequently have severe headaches? (If yes, answer the following)

Yes No Do they cause visual trouble?

Yes No Do they feel like a tight band?

Yes No Do you have difficulty seeing?

Yes No Do they hurt most in the back of the head and neck?

Yes No Do they wake you up when sleeping?

Yes No Does aspirin relieve them?

Yes No Do they occur on one side of your head?

Have you recently had or do you have any of the following? (Circle)

Yes No Have you ever fainted?

Yes No Spells of dizziness?

Yes No Loss of strength or feeling in any part of your body?

Yes No Ringing in ears?

Yes No Do you have inflamed eyes?

Yes No Do you frequently have bleeding gums?

Yes No Do you frequently have trouble swallowing?

Yes No Have you ever had a convulsion, fit or seizure?

Yes No Loss of hearing?

Yes No Pains in ears?

Yes No Nosebleeds?

Yes No Do you frequently have nausea or vomiting?

Yes No Do you have persistent hoarseness?

Have you ever had or recently experienced shortness of breath? If so: (Circle)

Yes No Doing your usual work?

Yes No Climbing a flight of stairs or with exertion?

Yes No Which awakens you at night?

Yes No Accompanied by wheezing?

Yes No Which causes you to cough?

Yes No Do you have a persistent cough?

Yes No Have you ever coughed blood?

Yes No Do you have pain with breathing?

Have you recently had or do you now have chest pain or tightness in the chest which begins: (Circle)

Yes No When exerting yourself?

Yes No When walking against a wind?

Yes No When walking up a hill?

Yes No After a heavy meal?

Yes No When upset or excited?

Yes No When walking lost?

Yes No Have you experienced palpitations, racing heart or irregular heartbeat?

Yes No Does it radiate down the arm?

Yes No Does it disappear if you rest?

Yes No Does it occur at rest?

Yes No Do you sleep on more than one pillow?

If you have chest pain or lightness, please explain_____

Pertaining to bowel habits, have you recently experienced: (Circle)

Yes No A change in bowel habits? Now or since when? _____

Yes No Cramping pain in the abdomen? Now or since when? _____

Yes No Alternating diarrhea and constipation? Now or since when? _____

Yes No Pain during or after a bowel movement? Now or since when? _____

Yes No Mucous in the stool? Now or since when? _____

Yes No Blood in the stool? Now or since when? _____

Yes No Black stools? Now or since when? _____

Yes No Excessive bloating or belching? Now or since when? _____

Yes No Do you require use of strong laxatives or enemas? Now or since when? _____

Have you recently had or currently have: (Circle)

Yes No Burning or pain when urinating? Now or since when? _____

Yes No Loss of control of bladder? Now or since when? _____

Yes No Blood or gravel in urine? Now or since when? _____

Yes No Dark colored urine? Now or since when?

Have you recently had or currently have: (Circle)

Yes No Trouble starting to urinate? Now or since when? _____

Yes No Trouble holding the urine or frequent dribbling? Now or since when? _____

Yes No Getting up frequently at night? Now or since when? _____

Yes No Kidney stone passing? Now or since when? _____

Yes No Unusual thirst? Now or since when?

Have you recently had or currently have: (Circle)

Yes No	Pain in calves of legs when walking?	Now or since when? _____
Yes No	Pain in calves of legs at rest?	Now or since when? _____
Yes No	Cramps in legs at night?	Now or since when? _____
Yes No	Pain in the big toe?	Now or since when? _____
Yes No	Varicose veins?	Now or since when? _____
Yes No	Phlebitis or inflamed leg veins?	Now or since when? _____
Yes No	Swelling in the ankles?	Now or since when? _____
Yes No	Pain or swelling in the joints?	Now or since when? _____

To be answered my MEN only

Have you recently had or currently have: (Circle)

Yes No	Loss of sexual activity or drive? For how long?_____
Yes No	Treatment for genitals (private parts)?
Yes No	Discharge from penis?
Yes No	Hernia (rupture)?
Yes No	Prostate trouble?
Yes No	Painful intercourse?

Describe briefly your present medical symptoms:

List All Surgeries- If you have never had any surgeries then please (circle) not applicable'

Surgery: Date:

When and where was your last mammogram?

When and where was your last colonoscopy?

When and where was the last lab work you had done?

Have you had any imaging done, when and where? (i.e. MRI, CT, ultrasound)

Please list all prescribed medications, dose and how you are taking them.

Any supplements/Herbs/ Over the counter medications

Patient Health Questionnaire-2 (PHQ-2)

Name: Date:

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: ____0____+_____+_____+_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

Erland Internal Medicine

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____ Sex: M F

Home Phone: _____ Cell Phone: _____ DOB: _____

SSN #: _____ Driver's License #: _____ State: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Race: American Indian/Alaska Native Asian White

Black/African American Native Hawaiian/Pacific Islander Other

Email: _____

Employer Name: _____ Work Phone: _____

Emergency Contact #1: _____ Relationship: _____

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

Emergency Contact #2: _____ Relationship: _____

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

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____ DOB: _____

INSURANCE ASSIGNMENT & RELEASE

I, the undersigned, have insurance coverage through _____ and assign directly to Erland Internal Medicine, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Erland Internal Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature Date

Erland Internal Medicine

Acknowledgement and authorization

Name: _____ DOB: _____

Please initial each line, sign, and date below:

_____ I have read and understand the HIPAA/Privacy Policy of Erland Internal Medicine.

_____ I hereby assign my insurance benefits to be paid directly to Erland Internal Medicine.

_____ I authorize Erland Internal Medicine to release medical information required to process my claim.

_____ I understand the financial policy of Erland Internal Medicine.

_____ I authorize Erland Internal Medicine to leave information regarding my medical care and test results on my voicemail.

_____ I understand Erland Internal Medicine may charge me a late cancellation/no show fee of $150.00. That I could be terminated after 2 late cancellation/no shows.

** Erland Internal Medicine is authorized to discuss my medical care and/or tests results with:

Name: _____ Relationship: _____

Contact Number: _____

Signature: _____ Date: _____

IMPORTANT EDUCATIONAL INFORMATION FOR ANNUAL WELLNESS/PREVENTIVE EXAMS

This information is to help you avoid confusion about your insurance coverage and scheduling for specific types of visits.

I. Routine annual wellness/preventive exams only focus on preventive measures which include:
- Review of Wellness Labs
- Vaccinations
- Age-appropriate Screenings
- Physical Exam

II. Routine annual wellness/preventive exams do NOT include:
- The evaluation of NEW or EXISTING medical conditions.
- Prescribing NEW medications and/or refills of EXISTING medications.

III. Diagnostic medical conditions are considered distinct services and are separate from the annual visit. Diagnostic medical conditions include, but are not limited to:
- Hypertension
- Diabetes
- Anxiety
- Depression
- Thyroid Disorders
- Hyperlipidemia

IV. Please review the "Charges for a Wellness/Annual Physical/Preventive Exam" form for more detailed information on charges associated with the annual exam.

Scheduling a separate appointment from the annual wellness for new or existing health issues is preferred to allow for adequate evaluation time. If you are unable to schedule a separate appointment, please ask the receptionist to add additional time to your appointment. (Failure to do so may result in complaints not being addressed at your appointment.)

Please be mindful of what a preventive exam covers. We highly encourage you to schedule the appropriate appointment to avoid frustration by both you and the office. We allocate the proper amount of time for the services you request to keep the office running smoothly and to avoid extended waiting times.

We appreciate your understanding and look forward to continuing to collaborate with you to achieve the best possible outcomes and health status.

Please sign and date below to acknowledge that you understand the information above:

Print Name: _____ Date: _____

Signature: _____ DOB: _____

MISSION STATEMENT

The mission of Erland Internal Medicine, P.C. is to provide quality medical care in a relaxed and supportive environment as a collaborative effort between patient and physician. To accomplish this goal, we require an understanding on your part, as the patient, as to how you can assist in accomplishing this goal.

Please read the following information and sign the bottom upon completion.

Our regular business hours are from 8 a.m. to 5 p.m. Monday through Thursday. For your convenience, we are open on the first and third Friday every month from 8 a.m. to 12 p.m. Our Friday schedule may change and we may not be open, please keep this in consideration.

I request that all medical problems, questions and medication refills be dealt with during normal business hours. I am available outside of working hours and weekends for urgent and emergent issues only.

I have privileges at St. Alphonsus and St. Luke's medical centers. If you have a medical emergency, it is requested that you call 911 and go directly to the emergency room at St. Alphonsus or St. Luke's or the nearest hospital.

No medication refills will be given outside of normal business hours or on weekends. Please contact your pharmacy first for refills with **48 hours advance notice required**.

Patients are expected to give 48 hours advance notice if an appointment cannot be kept. Failure to contact us for a missed appointment may result in dismissal from Keri Erland Internal Medicine P.C.

Failure to show will result in a charge to your account of $150.00. Two failures to show will result in dismissal from Erland Internal Medicine, P.C.

It is requested that **payment be made at the time of service**. Patients who demonstrate financial hardship may qualify for long term payment arrangements. Please contact our billing manager with questions.

I have read the above statement and have had any and all of my questions answered adequately.

Name_____ Date_____

Erland Internal Medicine, P.C.

3667 N Locust Grove Rd.
Meridian Idaho 83646
Phone: 208-939-9090 ♦ Fax: 208-939-9911

PAYMENT POLICY

Thank you for choosing Erland Internal Medicine, P.C. for your health care. Our goal is to provide high quality, thorough, effective treatment and care to each and every patient. In return we ask each patient to accept responsibility for their health care and responsibility for paying all fees related to his/her treatment. Payment can be made by cash, check, Visa, or MasterCard.

1. **Insurance**. We participate in most insurance plans, Erland Internal Medicine, P.C. will bill your insurance company on your behalf. The procedure for obtaining insurance payments varies widely depending on the insurance plan and the insurer, so we rely on you to provide us with the necessary information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. A $50 charge will be collected at the time of your visit if: (1) you do not have insurance coverage, (2) are not insured by a plan with whom we do business, or (3) do not have a current insurance card. Any remaining balance will be billed to you and must be paid in full 30 days after receiving your statement. If your insurance company pays for the visit, you will be sent a refund.
2. **Co-payments and deductibles**. All co-payments must be paid at the time of the service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Any deductible will need to be paid in full 30 days after receiving your statement.
3. **Non-covered services**. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance companies. You must pay for these services in full 30 days after receiving your statement.
4. **Nonpayment**. Any remaining balance due after the insurance carrier has paid will be sent to your home. This amount is due in full 30-days after receipt. If you are not able to pay your balance in full, you must call Erland Internal Medicine, P.C. before your bill is due. If payment is not received in a timely manner and your account becomes delinquent, please be aware that Erland Internal Medicine, P.C. may ask you and your immediate family to find another health care provider and may also turn your account over to a collection agency. If this occurs, you will be notified by regular and certified mail that you have 30-days to find another health care provider. During that 30-day period, Erland Internal Medicine, P.C. will only be able to treat you on an urgent or emergency basis.
5. **Missed appointments**. Our policy is to charge for missed appointments that are not cancelled within a reasonable amount of time. If you realize that you won't be able to keep your appointment, please let us know as soon as possible. If you miss any of your appointments, please be aware that you may be charged a $150.00 missed appointment fee.
6. **Insufficient funds**. If we receive a check back for insufficient funds, please be aware that you will be charged a $10.00 service fee.
7. **Statements**. Statements will be sent out on a monthly basis to those patients who have a balance of $3.00 or more.
8. **Refunds**. Any refunds due to patients will only be paid after they reach a balance of $5.00 or more.

I certify that I have received a copy of Erland Internal Medicine, PC's Payment Policy and agree to all terms and conditions as stated. I understand it is my sole responsibility to verify my medical coverage with my insurance company. I also understand that all remaining fees associated with my office visit(s) will be due in full 30 days after I receive a statement from Erland Internal Medicine, PC.

Printed Name: _____ Signature: _____ Date: _____

Dear Patient,

The doctor-patient relationship requires both cooperation and mutual trust. I will strive to provide you with the best possible medical care, a dn ask that you participate in the effort to the best of your ability.

This patient handout was prepared to help you become better acquainted with the nature of my medical practice. I welcome any questions you may have about our professional relationship.

My Background;

I am a graduate of the University of Washington School of Medicine and did my internship and residency at Oregon Health Sciences University in Portland, Oregon. I became certified by the American Board of Internal Medicine in 1995 and recertified in 2005. This means that I am qualified, after extensive testing, to specialize in Internal Medicine. I practiced in Boise from 1995-2009 and in Corvallis, Oregon from 2009-2012.

As an internist, my experience includes extensive outpatient and inpatient training in adult medicine. Although I have been trained to care for patients with multiple medical problems, I would like to focus a great deal of care on the preventative aspects of disease, thereby allowing the patient an active role in their healthcare. I have privileges at both St. Alphonsus and St. Luke's medical centers.

As a small medical practice, I feel it is necessary to begin with several basic rules that will allow me to continue to provide quality medical care in a relaxed and supportive environment.

Our regular business hours are from 8:00am to 5:00pm Monday through Thursday. Per your convenience, we are open on the first Friday of the month, from 8:00am to noon.

It is requested that all medical problems and medication refills e dealt with during regular business hours. In an emergency, call 911 or go to the emergency department at St. Alphonsus or St. Luke's or your nearest hospital. I am available by phone after usual business hours for emergency issues only.

The policy regarding prescriptions is that all medication refill requests be made 48 hours in advance during normal hours of operation. This can be done through your pharmacy, which will then contact me. No prescriptions will be filled after hours or on weekends so please plan ahead. No narcotic medications will be given outside of the regular business hours.

Payment is expected at the time of services.

Fees for routine office visit and laboratory tests are posted at the reception desk. You are invited to review the fee schedule with the billing manager or receptionist, who will be happy to explain it in more detail.

My office bills monthly, if you have questions about your bill, or if you have financial difficulty that may require an adjustment in your payment schedule, please let us know. We want to try to accommodate patients in this regard.

If you find an error on your bill, bring it to our attention so that we can correct it. Services will be billed based on the doctor's services I provide on the date of your visit. We will not change coding.

Please find out before your appointment if you have wellness or preventative benefits. Please inform us at the time of your annual physical since coding cannot be changed after the day of your appointment.

I am as concerned as you are about the rising medical costs and I am doing my best to keep fees reasonable by only prescribing tests, treatments, and medications that I believe are necessary. Whenever practical, I encourage patients to share in the decisions about their medical care.

About you...

Because I think that it is important for you and your family to have confidence in the medical treatment you receive and because it is both necessary and desirable that you participate in maintaining good health habits, I hope that you can assist me in the following;

Keep your appointments. If you must cancel or reschedule an appointment, please let us know **24 hours in advance**, so that other patients may be scheduled. If the appointment falls on a Monday, you must call by Friday at 12:00 (end of day). It is your responsibility to reschedule a return visit. After two no shows or two late cancellations you will be dismissed from the practice.

Follow medical advice. A doctor's treatment or medication prescription is only part of the program to keep you in good health. Medical advice is always given for your benefit and your cooperation is essential.

Ask questions whenever you do not understand your treatment or my medical advice. Sometimes, good practice requires that I tell you about risks associated with treatment or the use of medications, as well as the limitations of both. You are always welcome to ask for more details if you wish.

Always report any problems that you have with medications or treatment.

Let us know if you have a complaint. Medicine is very complex. New research and experience constantly provide beneficial changes in diagnosis and treatment. Although every physician wishes to do their best, no doctor can guarantee a cure or promise a perfect result in every case.

Thank you for choosing Erland Internal Medicine for your medical care. I am excited to be in private practice in Boise, and I look forward to working with you to improve your health for many years to come.

Keri Erland, M.D.

Erland Internal Medicine
3667 N Locust Grove Rd.
Meridian Idaho 83646
208-939-9090

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to your use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health 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 disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at, or get copies of, your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $5.00 for the first page and $0.50 for each additional page of personal health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that

format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (**You must make your request in writing.**) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Kerilynn Erland, MD

Telephone: 208-939-9090 Fax: 208-939-9911

Address: Erland Internal Medicine
3667 N Locust Grove Rd.
Meridian Idaho 83646