

**PATIENT INFORMATION**

Adult  Minor

If the patient is a minor, the Adult/Guardian who brings the child to the appointment will be responsible for all charges, copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

Name: \_\_\_\_\_  
First Initial Last

Gender:  Male  Female

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Phone: \_\_\_\_\_  Home  Work  Other  
Phone: \_\_\_\_\_  Home  Work  Other

Marital Status:  Married  Single  Divorced  Other

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

**PATIENT EMPLOYMENT**

Employed  Retired  Unemployed  Other

Phone: \_\_\_\_\_  Home  Work  Other

Employer: \_\_\_\_\_

**ALTERNATE CONTACTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GUARANTOR**

Same as Patient  Other

Name: \_\_\_\_\_  
First Initial Last

**GUARANTOR EMPLOYMENT**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Phone: \_\_\_\_\_  Home  Work  Other

Phone: \_\_\_\_\_  Home  Work  Other

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**PRIMARY INSURANCE**

In the Name Of  Patient  Guarantor  Other

Patient's Relationship to Insured  Self  Spouse  Child  Other

Name: \_\_\_\_\_  
First Initial Last

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Phone: \_\_\_\_\_  Home  Work  Other

Phone: \_\_\_\_\_  Home  Work  Other

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group ID: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

**SECONDARY INSURANCE**

In the Name Of  Patient  Guarantor  Other

Patient's Relationship to Insured  Self  Spouse  Child  Other

Name: \_\_\_\_\_  
First Initial Last

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
City State Zip

Phone: \_\_\_\_\_  Home  Work  Other

Phone: \_\_\_\_\_  Home  Work  Other

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group ID: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

I authorize Debra R Miller, MD, LLC, to release to my insurance carrier(s) or its intermediaries any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and I request payment of medical insurance benefits to Debra R Miller, MD, LLC, who accepts assignment.

Patient (or Responsible Party) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# MEDICAL HISTORY

Patient: \_\_\_\_\_ Date of Birth: / / Today's Date: / /

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  YES  NO If YES, list below: \_\_\_\_\_

List all Medications you are currently taking (including common over-the-counter drugs; i.e, aspirin, etc): \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<u>LUNGS:</u>	YES	NO	<u>OTHER SYSTEMIC:</u>	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis/Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<u>VASCULAR:</u>			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy, or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>			
			List any other diseases or conditions _____		

Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_  
 Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day  
 Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How Much? \_\_\_\_\_  
 Have you ever been exposed to HIV (AIDS)?  YES  NO  
 Have you ever had a bad reaction to dental anesthesia (Novicaine)?  YES  NO

**SKIN:**

When you are exposed to the sun do you:  Tan only  Tan & burn  Burn  
 Have you ever had skin cancer?  YES  NO  
 Has anyone in your family had skin cancer?  YES  NO If YES, who? \_\_\_\_\_  
 Do you have a history of any specific skin diseases?  YES  NO  
 If YES, please list: \_\_\_\_\_  
 List any other disease or condition we should know about: \_\_\_\_\_  
 List surgical procedures you have had in the last 6 months: \_\_\_\_\_

**Please answer the following questions:**

Do you bleed easily?  YES  NO  
 (Women) Are you pregnant?  YES  NO Due Date: \_\_\_\_\_  
 Do you have an artificial joint(s)  
 or valve(s)?  YES  NO  
 Do you require antibiotic  
 prophylaxis before surgical  
 procedures?  YES  NO  
 What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:  Patient  Medical Assistant \_\_\_\_\_  
Initials Debra R Miller, MD Date: / /

With the increase in all forms of skin cancer, many people are interested in having their skin examined to look for skin cancer. Recent studies have shown that up to one out of twenty patients who visit a dermatology office has a pre-cancerous or a cancerous mole or spot that they were unaware of, which was discovered by having the doctor look at the skin from head to toe.

In addition, changes in the skin in areas covered by clothing are often important clues in diagnosing your skin problems. It is Dr. Miller's standard policy to offer all new patients the option of a visual examination of the skin from head to toe to check for skin cancer as part of their first visit. Skin cancer is most treatable when detected in its early stages.

Dr. Miller would like to offer you the opportunity to look for this easily prevented disease:

- The doctor will leave the room, and you will be allowed to undress so the skin may be checked visually.
- You may keep on your undergarments, and a drape will be provided to protect your modesty.
- The examination is painless and requires only several minutes.
- No x-rays or machines are involved.

You may feel free to request this examination at any visit.

- Yes, I am interested in having a total body skin examination at this visit to check for skin cancer.
- Yes, I am interested in having a total body skin examination at a later date to check for skin cancer.
- No, I am not interested in having a total body skin examination to check for skin cancer.

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Patient's signature

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Date

**DEBRA R. MILLER, M.D., L.L.C.**

53 Granite Street, Suite D  
New London, CT 06320-5917  
(860) 447-1419

## Financial Payment Policies

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### 1. Payment is due at time of service

- If you are not covered by one of the insurance companies listed below, we accept cash, check, bank debit cards, and most major credit cards including Discover, MasterCard & VISA. We will assist you in processing an insurance claim for your reimbursement provided we are given the necessary insurance information and releases.
- If you are covered by one of the plans listed below, payment of any co-pays and/or deductibles required by your insurance plan will be collected at the time of service. We accept cash, check, bank debit cards, and most major credit cards including Discover, MasterCard & VISA.
- All cosmetic procedures must be paid for at the time of service.

### 2. Insurance plans - This office accepts assignment to the following insurance companies:

Aetna	Health Connecticut	Oxford
Anthem Blue Cross/Blue Shield (but <i>not</i> Blue Care Family Plan )	Health Net (but <i>not</i> Healthy Options)	PHCS
ConnectiCare	Mashantucket/Pequot	Taft-Hartley Health Funds
CIGNA	Medicare	Tricare
GHI	MultiPlan	United Health Care
		Most secondary insurance plans

- 3. Proof of insurance must be available at time of service** - It is mandatory under Federal law that you tell us if you know that one or more insurance carriers is responsible for paying for your treatment (Section 1128B of the Social Security Act and 31 USC 3801-3812).
- 4. Referrals** - It is *your* responsibility to ensure **that any primary care referrals required by your insurance coverage** have been made ***prior*** to your appointment. If a referral is required by your insurance plan, we will not be able to provide care without the referral.
- 5. Deductibles** - Payment of deductibles is required at time of service. TriCare deductible begins October 1 of the calendar year. Others begin January 1.
- 6. Co-pays** - Payment of any co-pay amount is required at time of service.

***Please do not ask us to bill you***

- 7. Returned checks** - You will be charged a \$25.00 fee for any check returned from the bank.
- 8. Delinquent accounts** - Delinquent accounts may go to a collection agency after 90 days. If your account is turned over to a collection agency, you will be responsible for any charges including attorney fees. If you are having difficulty paying your bill, please contact the office manager to make financial arrangements *before* your account is turned over and is out of our hands.

**I have read and understand the above financial policy. I agree that all charges are my responsibility regardless of insurance coverage from the date services are rendered. I may be billed separately for laboratory and pathology services.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Debra R. Miller, MD, LLC

**NOTICE OF PRIVACY PRACTICES**

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)  
**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320

**C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS**

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Practice employees – including, but not limited to, our doctors and medical assistants – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for treatment of a wart. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

**D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**4. Law Enforcement.** We may release IHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

**5. Research.** Our practice may use and disclose your IHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IHI is being used only for the research and (iii) the researcher will not remove any of your IHI from our practice; or (c) the IHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IHI of the decedents.

**6. Serious Threats to Health or Safety.** Our practice may use and disclose your IHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**7. Military.** Our practice may disclose your IHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**8. National Security.** Our practice may disclose your IHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**9. Inmates.** Our practice may disclose your IHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**10. Workers' Compensation.** Our practice may release your IHI for workers' compensation and similar programs.

**E. YOUR RIGHTS REGARDING YOUR IHI**

**1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

**2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IHI, you must make your request in writing to **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320**. Your request must describe in a clear and concise fashion:

- (a) The information you wish restricted;
- (b) Whether you are requesting to limit our practice's use, disclosure or both; and
- (c) To whom you want the limits to apply.

**3. Inspection and Copies.** You have the right to inspect and obtain a copy of the IHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320** in order to inspect and/or obtain a copy of your IHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IHI kept by or for the practice; (c) not part of the IHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IHI for non-treatment or operations purposes. Our practice is not required to document use of your IHI as part of the routine patient care (for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing to **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320**.

**7. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

**8. Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHI for the reasons described in the authorization. Please note, we are required by State law to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320**.

**Debra R. Miller, MD, LLC**

**Acknowledgment of Receipt of Notice of Privacy Practices**

By signing this form, I acknowledge that I have been given a copy of the *Notice of Privacy Practices* of Debra R. Miller, MD, LLC. I understand that the *Notice of Privacy Practices* provides information about how Debra R. Miller, MD, LLC may use and disclose my protected health information.

I understand that this *Notice of Privacy Practices* is subject to change, and that I have the right to request a copy of the most recent *Notice of Privacy Practices* at any time by contacting the Privacy Officer at Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320.

I acknowledge receipt of the *Notice of Privacy Practices* of Debra R. Miller, MD, LLC.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/guardian/conservator)

**Inability To Obtain Acknowledgement**

- Patient was given a *Notice of Privacy Practices* but refused to sign this form
- Patient refused to take a copy of the *Notice of Privacy Practices* and refused to sign this form

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(provider representative)

Debra R. Miller, MD, LLC

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

With my consent, Debra R. Miller, MD, LLC, may use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I have been given a copy of Debra R. Miller, MD, LLC's, Notice of Privacy Practices to which I may refer for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Debra R. Miller, MD, LLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Debra R. Miller, MD, LLC, 53 Granite Street, Suite D, New London, CT 06320.

With my consent, Debra R. Miller, MD, LLC, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including, but not limited to, laboratory results.

With my consent, Debra R. Miller, MD, LLC, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and laboratory results.

With my consent, Debra R. Miller, MD, LLC, may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request in writing that Debra R. Miller, MD, LLC, restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions. If it does agree, however, it is bound by that agreement.

**By signing this form, I am consenting to Debra R. Miller, MD, LLC's use and disclosure of my PHI to carry out TPO.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Debra R. Miller, MD, LLC, may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian