GENOVESE
Primary Care
CYNTHIA GENOVESE, M.D.

PATIENT REGISTRATION

PATIENT INFORMATION					
PATIENT'S LAST NAME	FIRST	MIDDLE INIT.	TITLE	MARITAL STATUS	
			MISS MS MRS MR	S M W D	

D.O.B	AGE	SEX	SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	CELL PHONE NUMBER
		M ☐ F ☐			

DRIVERS LICENSE	PRIMARY LANGUAGE	RACE	ETHNICITY

ADDRESS	CITY	STATE	ZIP

OCCUPATION	EMPLOYER	EMPLOYER PHONE NUMBER

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD AND I.D. TO THE RECEPTIONIST.)

SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE	MARITAL STATUS

D.O.B	AGE	SEX	SOCIAL SECURITY NUMBER	REFERRING PHYSICIAN
				WORK COMP RELATED? YES ☐ NO ☐
PLEASE INDICATE PRIMARY INSURANCE			COPAY AMT $_____	MOTOR VEHICLE ACCIDENT RELATED? YES ☐ NO ☐

PRIMARY INSURANCE COMPANY			START DATE/DATE OF ACCIDENT
POLICY & GROUP NUMBER			
CLAIM NUMBER			
PATIENT'S RELATIONSHIP TO SUBSCRIBER			

SECONDARY INSURANCE IF APPLICABLE

SUBSCRIBER'S LAST NAME	FIRST NAME	D.O.B	SOCIAL SECURITY NUMBER
PLEASE INDICATE SECONDAY INSURANCE	COPAY AMT $_____	MEDICARE ☐ MVA ☐ WORKERS COMPENSATION ☐	
SECONDARY INSURANCE			START DATE/DATE OF ACCIDENT
POLICY & GROUP NUMBER			
CLAIM NUMBER			
PATIENT'S RELATIONSHIP TO SUBSCRIBER			

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE	RELATIONSHIP TO PATIENT	HOME PHONE NUMBER	CELL PHONE NUMBER

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 GENOVESE FAMILY PRACTICE OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

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Office: 609-245-0416
Fax: 609-245-0419
Email: Office@genovesemd.com

New Patient Questionnaire

Name: _____ **DOB**: _____

Phone No.: _____ **Email:** _____

Address: _____

How did you hear about us? _____

Allergies/Drug Reactions (Please list medication & reaction):

_____
_____
_____
_____

Please list current medical problems:

_____
_____
_____
_____

Please list other doctors who are also currently providing care:

_____
_____
_____
_____

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Smoking History

☐ **Never smoked**

☐ **Previous smoker (age started) _____ (age stopped) _____**

On average, how many packs a day? _____

☐ **Current smoker (age started) _____**

On average, how many packs a day? _____

Do you drink wine, beer, or other alcoholic beverages? ☐ **Yes** ☐ **No** ☐ **Socially**

If yes, how many times in the last year have your consumed 4 or more drinks on one occasion? _____

Have you ever had a drinking problem? ☐ **Yes** ☐ **No**

How many cups of coffee or caffeinated beverages do you consume daily? _____

Do you use: marijuana, cocaine, or any other street drugs/prescriptions not prescribed for you?

☐ **Yes** ☐ **No** (*Leave blank if you would prefer to discuss this with the doctor*)

Family History

*****Please be sure to include: cancer, diabetes, high blood pressure, strokes, tuberculosis and other important illnesses*****

	Age if Living	Age at Death	Health problems/Cause of death
Mother			
Father			
Brothers/Sisters:			
Children:			

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*Please list all medications you are taking, including over the counter medications, vitamins, herbs, and other treatments. Include the name of the Dr. who prescribed it and WHY you are taking it. If you aren't sure on why you're taking the medication, please indicate by writing, "Don't know", if that is the case, please ask your doctor to explain why and how to use the drug properly. Also, ask about the drugs side effects and what you should do if you experience a side effect.

*Please remember to update your medication list when your doctor stops, changes or updates your medications. Please bring your medication list with you to doctors, ER, walk-in clinic visits, nursing home, home health visits and to the hospital. *If you are unable to bring a list with you, please bring your bottles.*

Medication Chart

Medication	Prescribed by	Dose	Frequency	Purpose

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Past Medical History:

Please check whether you have ever had the following:

	Yes	No		Yes	No
Hypertension			Pancreatitis		
Diabetes			Kidney Problems		
Cancer			Abnormal Pap Smear		
Heart Murmur			High PSA (men only)		
Heart Problems			Seizures		
Asthma			Depression/Anxiety		
Emphysema/COPD			Stroke		
Positive skin test for TB			Blood Problems		
Tuberculosis			Thyroid Problems		
Blood Clots			Arthritis		
Asbestos exposure			Radiation treatments to head/neck		
Ulcers			STDs		
Colon Polyps			HIV infection		
Gallbladder Problems			**Other** (**List**):		
Hepatitis/Jaundice					
Liver Problems					

VACCINATIONS	Yes	No	TESTS	Yes	No
Tetanus			Stool cards for colon cancer testing		
Influenza (Flu Shot)			Colonoscopy		
Influenza (H1N1)			Sigmoidoscopy		
Pneumonia			Bone density		
Hepatitis A			Mammogram		
Hepatitis B			Pap Smear (Women Only)		
Shingles			PSA (Men Only)		
Others:			Exam by eye doctor		

***Please check whether or not you CURRENTLY HAVE, or HAD in the PAST FEW WEEKS:**

	Yes	No		Yes	No
Fatigue			Nausea		
Fever/Chills			Vomiting		
Recent weight change			Abdominal Pain		
Headache			Black Tarry Stools		
Vision Problems			Rectal Bleeding		
Double Vision			Diarrhea		
Blurred Vision			Blood in Urine		

Continued on Next Page…

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Eye Pain			Frequent Urination		
Eye Itching			Too much Urine		
Hearing Loss			Getting up at Night to Urinate		
Ear Ache			Pain with Urination		
Ringing in Ears			Excessive Thirst		
Runny Nose			Weakness		
Nose Bleeds			Easy Bruising		
Nasal Congestion			Muscle Aches		
Snoring			Joint Pain		
Hoarseness			Joint Stiffness		
Sore Throat			Swelling in Arms or Legs		
Mouth Sores			Dizziness		
Breast Lump/Pain			Fainting		
Chest Pain			Memory Problems		
Irregular Heart Beat			Numbness		
Pounding Heart Beat			Anxiety/Depression		
Shortness of Breath			Stress		
Cough			Trouble Sleeping		
Wheezing			Hallucinations		
Decreased Appetite			Dry Skin		
Increased Appetite			Itching		
Difficulty Swallowing			Lump or Spot on Skin		
Heartburn			Rash		

MEN ONLY			**WOMEN ONLY**		
	YES	**NO**	Date of last menstrual cycle		
Straining with Urination				**YES**	**NO**
Pain/Lump on Testicle			Pelvic Pain		
Discharge from Penis			Abnormal Vaginal Bleeding		
Prostate Problems			Vaginal Discharge		
Difficulty with Erection			Sexual Difficulties		
Sexual Difficulties					

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GERIATRIC INTAKE

Please Complete if you are *over* 65, or if you have *concerns* about the topics listed below

Do you have medical Durable Power of Attorney for Healthcare? ☐ **Yes** ☐ **No**

(If yes, please bring a copy) **Name:** _____ **Relationship:** _____
Do you have a living will? ☐ **Yes** ☐ **No**
(If yes, please bring a copy)
Are you afraid of falling? ☐ **Yes** ☐ **No**
Have you fallen in the past year? ☐ **Yes** ☐ **No**
If yes, please tell us about your last fall:
Date:_____
How did this fall happen?

_____
_____
_____
_____

Did you see a doctor or other professional for treatment after this fall? ☐ **Yes** ☐ **No**
Do you use a walking aid such as a CANE or WALKER? ☐ **Yes** ☐ **No**
Do you drive? ☐ **Yes** ☐ **No**
We would like to know if you need help with any of the following and who helps you.

TASK	NO HELP	NEEDS HELP	WHO HELPS
Feeding Yourself			
Getting from Bed to Chair			
Getting to Toilet			
Getting Dressed			
Bathing			
Using the Telephone			
Taking your Medications			
Preparing Meals			
Managing finances/checkbook			
Doing Laundry			
Housework			
Shopping for Groceries			
Driving			
Doing Handyman Work			
Climbing a Flight of Stairs			
Getting Places BEYOND Walking Distance			

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FINANCIAL POLICY

Thank you for choosing **Genovese Primary Care** as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask business office personnel. We ask that all our patients please take a minute to both read and sign our Financial Policy as well as complete our Patient Information Forms Prior to seeing the doctor.

Patient's portion of the payment, as well as any past due balances are due at the time services are rendered unless prior arrangements have been made with the billing department. We accept cash, personal check, money orders, travelers' checks and all major credit cards for payment.

We accept assignment with most major insurance companies and participating provider plans (Please see attached list). However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with YOU, not your insurance carrier.
2. All charges are your responsibility whether or not your insurance company pays or not.
3. Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 30-60 days we ask that you please contact the carrier to request payment. Please inform our office of your carriers' response.
5. Returned checks will be subject to a $25.00 insufficient fund fee. We will notify you by mail.
6. Unpaid balances over 90 days are subject to collections via small claims court, attorney, and/or collections agency with applicable collection fees.
7. Failure to cancel an appointment may result in a cancellation fee/No Show fee charge of $35.00 for each time you fail to notify to office.
8. If an attorney is utilized for collection of an outstanding balance, you will be responsible for attorney and court costs that are incurred.

We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize the release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Genovese Primary Care** the medical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims, until I chose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy, I understand that I am financially responsible for all charges incurred for my medical treatment.

_____ _____

Patient/Guardian Signature Date

_____ _____

Printed Name of Patient Relationship to patient if not patient

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NO SHOW POLICY

WE UNDERSTAND THAT THERE ARE OFTEN LEGITIMATE REASONS FOR HAVING TO CANCEL AN APPOINTMENT...HOWEVER WE ASK YOU TO PLEASE SHOW SOME CONSIDERATION BY CALLING IN ADVANCE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT AS WE WOULD LIKE TO HAVE THE OPTION TO OFFER THAT APPOINTMENT TO ANOTHER PATIENT WHO NEEDS TO BE SEEN.

THIS LETTER IS TO NOTIFY YOU THAT FAILURE TO PROVIDE A 12 HOUR NOTICE OF CANCELLATION WILL RESULT IN A $35 NO SHOW FEE

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS POLICY.

SIGNATURE OF PATIENT: _____

PRINTED NAME: _____

DATE: _____

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of my insurance benefits to Dr. Cynthia Genovese of Genovese Primary Care, for services rendered to my dependents or me by the physician. I understand, that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are a covered benefit. I understand, and agree, that I will be responsible for any co-pay or balances due that Dr. Cynthia Genovese of Genovese Primary Care is unable to collect from my insurance carrier for whatever reason.

MEDICARE / MEDICAL / OTHER INSURANCE BENEFITS

I certify that the information given by me in applying for payment under these programs is correct. I authorize, the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits to be made directly to Dr. Cynthia Genovese of Genovese Primary Care, on my behalf.

I request, that payment of authorized Medigap Benefits be made to either to me, or on my behalf to Cynthia Genovese, M.D., for any services furnished to me by that physician. I authorize any holder of Medicare information about me, to release to any secondary, or tertiary insurance carrier any information needed to determine these benefits payable for related services.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION

I certify that I have received, and read a copy of the Genovese Primary Care Patient Information Privacy Policy. I hereby authorize Dr. Cynthia Genovese, of Genovese Primary Care, to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. I understand my signature requests that, payment be made and authorizes release of any medical information necessary to pay claim. If item 9 of the HCFA-1500 Claim Form is completed.

AUTHORIZATION TO MAIL, CALL OR E-MAIL

I hereby certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Dr. Cynthia Genovese of Genovese Primary Care to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as: appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dr. Cynthia Genovese of Genovese Primary Care to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES

I understand, that I, may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand, that I am financially responsible for any, co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

_____ _____

Patient/Guardian Signature Date

_____ _____

*Optional – Witness to Patients Signature Date

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REFILL POLICY

WE ASK YOU TO PLEASE REQUEST ANY REFILLS OF MAINTENANCE MEDICATIONS AT THE TIME OF YOUR SCHEDULED APPOINTMENT.

IF YOU ARE DUE FOR A REFILL, PLEASE DO NOT WAIT UNTIL YOU TAKE YOUR LAST PILL. DR. GENOVESE WILL ADDRESS ALL MEDICATION REFILLS AT THE END OF HER DAILY OFFICE HOURS.

PLEASE ALLOW 24 HOURS FOR THE REFILL TO BE COMPLETED AND CHECK WITH THE PHARMACY TO VERIFY THAT THE REFILL IS READY.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS POLICY.

SIGNATURE OF PATIENT: _____

PRINTED NAME: _____

DATE: _____

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MEDICAL RECORD RELEASE

DATE:_____ **D.O.B**:_____

I, _____ hereby authorize: _____
_____
_____
_____ to release my records, including any pertinent bloodwork and diagnostic reports to:

Genovese Primary Care
639 Stokes Rd.
Suite 102
Medford, NJ 08055
Tel: 609-245-0416 || Fax: 609-245-0419

This medical record release is valid for one year from the date of my signature below.

_____ _____
Patient/Guardian Name Signature

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PRIVACY NOTICE – ACKNOWLEDGEMENT OF RECEIPT

Patient Name: _____

MRN #: _____

I, _____, acknowledge that I have received a copy
Patient name
of "Notice of Privacy Practices" from this office.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date

For Office Use Only:

- ☐ Patient refused to sign
- ☐ Patient unable to sign due to communication/language barrier
- ☐ Patient unable to sign to due emergency situation
- ☐ Other (please explain):

_____
_____

_____ _____
Office Representative Signature Date

The signed form is placed in the patient's medical record

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YOUR PRIVACY IS VERY IMPORTANT TO US! TO BETTER PROTECT YOUR PRIVACY, PLEASE LIST BELOW ANY INDIVIDUALS THAT WE MAY DISCUSS YOUR UPCOMING APPOINTMENT DATE/TIME, BLOOD WORK RESULTS OR IMAGING RESULTS.

NAME: _____
PHONE #:_____

NAME: _____
PHONE #:_____

NAME: _____
PHONE #:_____

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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 READ THIS NOTICE CAREFULLY!

All of the facilities and health care practitioners affiliated with Genovese Primary Care believe that your health information is personal and private. We keep records of care and services that you receive that participate with Genovese Primary Care and we are committed to keeping your health information private. In addition, we are required by law to respect your confidentiality. This Notice of Privacy Practices ("Notice") describes the privacy practices of all the GPC Providers and applies to all of the health records that identify you and the care you receive at the GPC facility. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of our Notice of Privacy Practices that is currently in effect.

I. GENOVESE PRIMARY CARE PROVIDERS

All of the GPC Providers – employed physicians, allied health care practitioners, doctors' offices, entities, facilities, and other affiliated programs, services, and health care practitioners – follow the terms of this Notice. The doctors and caregivers of other facilities who are not employed by or affiliated with GPC Providers may exchange information about you as a patient with GPC Providers for reasons of treatment, payment, and health care operations as discussed below. These health care practitioners also may give you other privacy notices that describe their own privacy practices.

When you become a patient of GPC, we will use your health information within the facility and disclose your health information outside the facility for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

II. PERMITTED USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment. We use your health information to provide you with health care services, We may disclose your health information to GPC Providers – doctors, nurses, technicians, medical or nursing students, or other persons at GPC Facilities – who need that information to take care of you. We also may disclose your health information to people outside GPC who may be involved in your health care, such as treating doctors, home care providers, pharmacies, drug or medical device experts, and family members. For example, a GPC Provider treating you at GPC may need to ask another doctor if you have diabetes because diabetes may complicate your treatment.

Payment. We may use and disclose your health information so that the health care you receive may be billed and paid by you, your insurance company, or third party. For example, we may give information about surgery you had at a GPC Facility to your health plan so it will pay us or reimburse you for the surgery. We also may tell your health plan about a treatment you are going to receive so we can get prior approval if your plan will pay for the treatment.

Health Care Operations. We may use your health information and disclose it outside a GPC Facility for our health care operations. These uses and disclosures help us operate our facilities to maintain and improve patient care. For example, we may use your health information to review the care you received and to evaluate the performance of our staff in caring for you. We also may combine health information many patients to identify new services to offer, what services are not needed, and whether certain therapies are effective. We also may disclose information to

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doctors, nurses, technicians, medical students, and other persons at GPC who are not directly involved in your care for learning and quality improvement purposes. We may remove information that identifies you so people outside GPC may study your health data without knowing who you are. Moreover, we may use and disclose your health information to our business associates and us involves the use or disclosure of your health information, that business associate is required to keep your information confidential.

More Stringent State and Federal Laws: The information in this Notice complies with the requirements of the Health Insurance Portability and Accountability Act (HIPPA) regulations. In some cases, other state or federal laws may be more stringent than the HIPPA regulations. GPC Providers will continue to abide by these more stringent state and federal laws. State law is more stringent when the individual is entitled to greater access to records than under HIPPA and when under state law, the records are more protected from disclosure than under HIPPA.

Contacting You. We may use and disclose your health information to reach you about appointments and other matters. We may contact you by mail, telephone or e-mail. We may leave voice messages at the telephone number with which you provide us, and we may respond to your e-mail messages to us.

Health-Related Services. We may use and disclose health information about you to send you mailings about health related products and services available at GPC.

III. PERMITTED USE AND DISCLOSURE WHERE YOU HAVE AN OPPURTUNITY TO AGREE OR OBJECT

Patient Information. Our facility maintain limited information about you in their patient directories, such as your name and possibly your location and your general condition (for example: good, fair, serious, critical, or undetermined). We usually give this information to people who ask for you by name. We may also include you religious affiliation in the directories and give your name to members of the clergy. Releasing directory information about you enables your family and others (such as friends, clergy, and delivery persons) to visit you in the hospital and generally know how you are doing. We will not release any of this information if you tell the hospital's admitting department or hospital's administration not to do so.

Promotional Communication. We do not share or sell your health information to companies that market health care products or services directly to consumers for use by those companies to contact you, such as drug companies. We do maintain a list of individuals to whom we may have sent health improvement information or health promotion materials and news about the GPC program. You may be included in this list. If you do not wish to be contacted for promotional communications, please notify us in writing to the GPC Privacy Officer at **Genovese Primary Care ATTN: Privacy Officer 639 Stokes Road, Suite 102 Medford, NJ 08055**

Other Uses. As described above, we will use your health information and disclose it outside GPC Facilities for treatment, payment health care operations, and when permitted or required by law. We will not use or disclose your health information for other reasons without your written authorization. For example, you may want us to release medical information to your employer. These kinds of uses and disclosures of your health information will be made only with your written authorization. You may revoke authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

IV. USES AND DISCLOSURES PERMITTED BY PUBLIC POLICY OR LAW WITHOUT YOUR AUTHORIZATION

Organ and Tissue Donation. We may release health information about organ, tissue and eye donor transplant recipients to organizations that manage organ, tissue, and eye donations and transplantation.

Coroners, Medical Examiners, and Funeral Directors. We will disclose your health information to a coroner, medical examiner or funeral director if it becomes necessary to identify a deceased person, to determine a cause of a death or as a necessary to carry out their duties.

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Public Health and Legal Matters. We will disclose health information about you outside GPC Facilities when required to do so by federal, state, local law, or by a court. We may disclose health information about you for public health reasons, like reporting reactions to medications, problems with medical products or death. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, and licensure.

V.YOUR RIGHTS REGARDING HEALTH INFORMATION

Right to Inspect and Obtain Copy. You have the right to inspect and obtain a copy of your completed health records unless your doctor believes the disclosure of that information could harm you. You may not see or receive a copy of information that has been gathered for a legal proceeding or that otherwise may be protected or prohibited by law. Your request to inspect or obtain a copy of your medical records must be submitted in writing to the Medical Records Department at the GPC Facility that maintains your records, you may appeal the denial to the GPC Privacy Officer at **Genovese Primary Care ATTN: Privacy Officer 639 Stokes Road, Suite 102 Medford, NJ 08055.** We will respond to you within 60 days. We may deny your request and if we do, we will tell you why and explain your options.

Right to Accounting. You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom an GPC Provider or GPC Facility has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures and the GPC Facility that maintains the records about which you want the accounting. We will not list disclosures made before the later of April 14, 2003 or those made 6 years before your request. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to the Medical Records Department of the GPC Facility that maintains the records. We will respond to you within 60 days. We will give you the first listing you request within any 12-month period free, but we will charge you for all other accountings requested within the same 12 months.

Right to Request Restrictions. You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree. You also may ask us to limit the health information that we use or disclose about you to someone who is involved in your care on the payment for your care, such as, a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated, and must identify the GPC Facility that maintains the information. The request also should describe the information you want restricted, state whether you want to limit the use or the disclosure of the information or both, and tell us who it is you do not wish to receive the restricted information. You must submit your request in writing to the Medical Records Department of the GPC Facility that maintains the information you want restricted. We will tell you if we agree with your request or not. If we do agree with your request, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health in a certain way or at a certain location. For example, you can ask that we only contact you work or by mail. Your request for confidential communications must be in writing, signed, and dated. It must identify the GPC Facility making the confidential communications and specify how or where you wish to be contacted, you need not tell us the reason for your request and we will not ask. You must send your written request to the GPC Privacy Officer at **Genovese Primary Care ATTN: Privacy 639 Stokes Road, Suite 102 Medford, NJ 08055**

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a paper copy of this notice at any GPC facility.

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Email: Office@genovesemd.com

VI.COMPLAINTS

If you believe you privacy rights have been violated, you may file a complaint with the GPC Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the GPC Privacy Officer, please submit your complaint in writing to the Privacy Official at the GPC Facility where you believe your rights have been violated. You will not be penalized for filing a complaint.

VII.CHANGES TO THIS NOTICE

We may change this Notice at any time. Any change in this Notice could apply to medical information we already have about you, as well as any information we should receive in the future. We will post a copy of the current Notice at each GPC Facility and on our website, **www.genoveseprimarycare.com**

If you have any questions about this Notice, you may contact the GPC Privacy Officer at the following address:
639 Stokes Road, Suite 102 Medford, NJ 08055