WELCOME FORM

JULIAN UNGAR-SARGON, M.D., PH.D

Today's date: | Referring Doctor:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

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

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

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

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

Referred to Dr. Ungar-Sargon by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

HEALTH INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

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

Is this person a patient here? ❑ Yes ❑ No

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

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑ Anthem of IN ❑ United Healthcare ❑ Arnett ❑ Medicaid Care Select

❑ Anthem Medicaid ❑ MDWise Hoosier Alliance ❑ Managed Health Services ❑ Medicaid Traditional ❑ Other

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

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

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

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

WELCOME FORM

MOTOR VEHICLE INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Agent Name:	Date of Accident: / /	Claim #:		Agent phone no.: ( )
Name of Insured:				
Name of Insurance:		Insurance Claims address:		Claims phone no.: ( )

WORKMANS COMPENSATION INFORMATION				
(Please give your insurance card to the receptionist.)				
Name of Adjustor:	Date of Injury: / /	Claim #:		Agent phone no.: ( )
Did patient go to Emerg Room? ☐ Yes ☐ No				
Name of Insurance:		Insurance Claims address:		Claims phone no.: ( )

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

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits be paid directly to Julian Ungar-Sargon, M.D., Ph.D., for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. If my account results in submission to the Collection Agency and/or Credit Bureau, I accept that a penalty of 25% will be added to my total balance and I will be responsible for any and all costs associated with Attorney and court fees.

I further authorize Julian Ungar-Sargon, M.D., Ph.D. to release any medical or incidental information that may be necessary to process my claims.

Patient/Guardian signature _Date_

Release of Medical Information: I understand that I may request in writing that Dr. Julian Ungar, MD., Ph.D restrict how private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand that Dr. Julian Ungar M.D., Ph.D is not required to agree to restrictions, but if they do agree then they are bound to abide by such restrictions.

Name of patient____________________ Initials X__________

I consent to disclosure of my Personal Health Information to the following family members or friends who live at my home or place of residence.

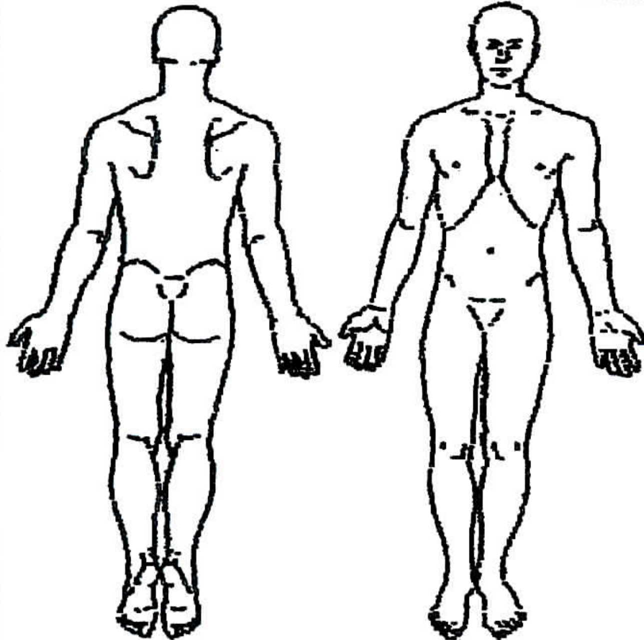
1.________________ 2.________________ 3.________________

I have read and understand The **"Notice Of Privacy Practices"** posted in the waiting room containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its "Notice of Privacy Policies" from time to time and that I may contact this organization at any time at the address listed to obtain a current copy of the Notice of Privacy Policies Practices. A copy can be given upon request.

X____________________
Signature of patient or guardian

Original – patient's chart

History of Present Illness (HPI)



Please Indicate Where Your Symptoms Are Located

(Mark above picture with "X" to show origin of pain. Use a broken line to show if pain travels/radiates.)

Patient Name:________________________________

1. What are your symptoms:______________________

____

____

____

2. Nature of pain/symptoms: (check all that apply)

□sharp □dull □throbbing □aching
□periodic □occasional □constant

3. When did your symptoms begin?(Date)___________

4. Was the onset of this episode gradual or sudden? (please check) □Gradual □Sudden

5. Which of the following **best describes** how your injury occurred?

□Car Accident □Incident at Work
□Lifting □fall
□hit by ball □during recreation/sports
□a blow to the face □Incident at a business
□overuse □trauma
□throwing □degenerative process
□running □dental appointment
□fight □Other__________________

6. Since onset, are you symptoms getting (check one):
□better □worse □not changing

7. Have you had similar symptoms in the past? ________

8. As the day progresses, do your symptoms: (Check one)
□increase□decrease □stay the same

9. Does the pain wake you at night? □Yes □No
If "yes", is it present □while lying still
□only when changing positions
□both

10. Do you have pain/stiffness upon getting out of bed in the morning? □Yes □No

11. In what position do you sleep?
□right side □back □ back,sides,stomach
□left side □chair □Other___________
□stomach □recliner

12. Since the onset of your current symptoms, have you had:
□difficulty controlling your bowels or bladder
□fever/chills
□ numbness
□numbness in the genital or anal area
□dizziness or fainting attacks
□weakness – Where?_________________
□unexplained weight change
□night pain/sweats
□malaise (vague feeling of bodily discomfort)
□problems with vision/hearing
□none of the above

13. My pain is **worse** when I (check all that apply)
□Sit □ go to/rise from sitting
□Stand □Squat
□Lie down □Sleep
□Walk □go up/down stairs
□Reach overhead □Reach in front of body
□Reach behind back □Reach across body
□Sleep □Talk
□chew □Yawn
□Breath in □Looking up overhead
□Swallow □Stress
□Turn my head □Lift
□Pull □Push
□Cough or Sneeze □Other:_______________

14. What relieves your symptoms? (check all that apply)
□sitting □bed rest □massage
□heat □standing □medication
□cold □walking □nothing
□stretching □exercise □physical therapy
□chiropractor □psychological Counseling □epidural steroid injections
□facet joint Injections □trigger point injections □joint injection(s)
□TENS unit □acupunture □surgery
□nerve block □traction □steroids

History of Present Illness (HPI)-continued

Patient Name:______________________________

15. Have you had any of the following tests?, If so, list date and which body part.
□x-ray______________________________
□MRI______________________________
□CT scan______________________________
□Myelogram______________________________
□Discogram______________________________
□Bone Scan______________________________
□Other______________________________

Past, Family and Social History

16. Have you ever had/been diagnosed with any of the following conditions? (check all that apply)

□Cancer(type)______________ □Heart problems
□Depression or anxiety □High blood pressure
□Stroke □Lung problems
□Kidney problems □Blood disorders
□Thyroid problems □Epilepsy/seizures
□Diabetes □Allergies
□Multiple sclerosis □Rheumatoid Arthritis
□Arthritis □Osteoporosis
□Head injury □Stomach problems
□Broken bone(what)__________ □Circulation/vascular problems
□Parkinson's disease □Emphysema
□Pancreatitis □Chicken pox
□Liver problems □Meningitis
□Deep Venous Thrombosis □Meningitis
□Peripheral Vascular Disease □High Cholesterol
□Infectious diseases(ie: hepatitis, AIDS, tuberculosis, etc.)______________________________

□Other______________________________

17. List all surgeries you have had in the past.

SURGERY	DATE

18. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
□Similar pain as yours □Arthritis
□Cancer(type)____________ □Diabetes
□Heart Disease □Osteoporosis
□ Psychological Condition □High Blood Pressure
□Other______________________________

19. How would you rate your general health?
□Excellent □Good □Average □Fair □Poor

20. Do you exercise outside of normal daily activities?
□No □Yes (describe exercise, sports,recreation consisting of)____________________

____

____

21. Do you drink caffeinated beverages?
□No □Yes- How many/much per day?_____

22. Do you smoke?
□No □Yes- How many packs per day?_____

23. What is your stress level?
□Low □Medium □High

24. Are you seeing any other health care provider for your current conditions? □No □Yes (list the providers)______________________________

____

____

25.Do you have any children? □No □Yes
If yes, how many?______________

26. Do you live...□alone □live with family members
□live with caregiver □home/apartment
□retirement complex □assisted living
□trailer home □Other______________

27. Does your living condition have the following...
□stairs(with railing)□no stairs □uneven ground
□stairs(no railing) □ramp □Elevator

28. What is your functional level?
□Independent in all activities(work, community, home)
□Independent self care(bathing, toileting,dressing,etc.)
□Need assistance with self care

29. What is your occupation?____________________

New Patient Medications List as of (date):			
Patient Name:		Date of Birth:	
Allergies: ☐ NKA ☐ Write Allergies and reaction to each below			
Medication Name	Dosage	Frequency	Prescribing Dr

CERTIFICATION

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

Patient's Signature Date Clinical Staff Witness Date

New Patient History Form Review by:

Julian Ungar-Sargon, M.D., Ph.D. Date

Julian Ungar-Sargon, M.D., Ph.D
123 S. McKinley Avenue
Rensselaer, IN 47978
Telephone: 219-866-7222 Fax: 219-866-7001

Patient's Responsibilities

Maintain healthy habits.

Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.

Comply with treatment plan prescribed by the provider.

Provide a responsible adult to transport patient from the facility and remain with him/her for a 24 hour period, if required by the provider.

Inform provider about any living will, medical power of attorney, or other directive that could affect his care.

Accept personal financial responsibility for any charges not covered by his insurance.

Patient, and any person accompanying patient, shall be courteous, well mannered, and respectful to the staff, physician, and other patients. Verbal abuse and threats are not acceptable and could result in patient dismissal.

I have read and fully understand the Patient's Responsibilities.

Printed Name: ____________________________

Signature: ____________________________

Date: ____________________________

SOAPP® Version 1.0-14Q

Name: ______________________________ Date: ______________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

Question	
1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

©2008 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

©2008 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org

Neurology and Pain Management

Julian Ungar-Sargon, M.D, Ph.D.

ACKNOWLEDGEMENT: RECEIPT OF NOTICE of PRIVACY PRACTICES.

I have received a copy of Neurology and Pain Management Notice of Privacy Practices.

Name (please print):______________________________

Signature:______________________________ Date:____________________

I am a parent or legal guardian of ______________________ (patient Name). I have received a copy of Neurology and Pain Management Notice of Privacy practices effective.

Name (please print):______________________________

Relationship to Patient: _______Parent _______Legal Guardian

Signature:______________________________ Date:____________________

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective (date) given to individual on ____________________(date)

_______In person _______Mailing _______Email Other____________________

Reason individual or parent/legal guardian did not sign this form:

_______Did not want to

_______Did not respond after more than on attempt

_______Other______________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

_______In person conversation______________________________

_______Telephone contact______________________________

_______Mailing______________________________

_______Email______________________________

_______Other______________________________

Staff (Siganture/Tile)______________________________ Date:____________________

123 S. McKinley Avenue
Rensselaer, IN 47978
219-866-7222
fax: 219-866-7001

Julian Ungar-Sargon, M.D., Ph.D.
130 Professional Ct. Ste. D
Lafayette, IN 47905
765-446-8888
fax: 765-446-8889

255 E 90th Dr, W3
Merrillville, IN 46410
219-756-0400
fax: 219-866-7001

NOTICE OF PRIVACY PRACTICES

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

Acronyms:
Protected Health Information (PHI): information about you, including demographic information, that may identify you and that related to your past, present, or future physical or mental health or condition and related health services.

TPO: Treatment, Payment, Healthcare Operations

NPP: Notice of Privacy Practices

This notice of Privacy Practices explains how we are required to maintain the privacy of your health information and describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon you request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail, by email or asking one at the time of your next appointment.

We may disclose your medical records only for each of the following purposes:

1. **Treatment** – means providing, coordinating or managing your health care and any related services. For example: providing PHI to a home health agency that provides care for you; to a laboratory or physicians (i.e.: specialists) to whom you have been referred or whom may be treating you to ensure that the physician has the necessary information to diagnose or treat you.

2. **Payment** – means such activities as obtaining payment for your health care services. Your PHI will be used, as needed, in determining eligibility or coverage of insurance benefits, reviewing services provided to you for medical necessity, billing, or collection activities and utilization review. For example: obtaining approval for a procedure may require that your relevant PHI be disclosed to the health care plan to obtain approval. Or, sending a claim (paper or electronic) for your visit to your insurance for payment.

3. **Health Care Operations** – means supporting the business activities of our office practice such as: quality assessment activities and improvement activities, cost management analysis, employee review activities, training of medical students, training potential employees, externship programs, customer service, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example:

Julian Ungar-Sargon, M.D., Ph.D.

123 S. McKinley Avenue
Rensselaer, IN 47978
219-866-7222
fax: 219-866-7001

130 Professional Ct. Ste. D
Lafayette, IN 47905
765-446-8888
fax: 765-446-8889

255 E 90th Dr, W3
Merrillville, IN 46410
219-756-0400
fax: 219-866-7001

NOTICE OF PRIVACY PRACTICES

a. We use a sign-in sheet at the registration desk where you will be asked to sign in your name and indicate the time you arrived and your appointment.
b. We call you by our name in the waiting area when your physician is ready to see you.
c. We may use or disclose you PHI, as necessary, to contact you to remind you of your appointment, either by telephone at home or work, or an appointment reminder postcard.
d. We will share your PHI with third party: business associates: that perform various activities (i.e.: billing, transcription services) for the practice. We will have a written contract between our office and a business associate that contains terms that will protect the privacy of your PHI.
e. We may use and disclose your PHI to send you a newsletter about our practice and the services we offer, as well as a Christmas card.
f. We may contact you about treatment alternatives or other health-related benefits.
g. We may use and disclose your PHI to a pharmaceutical representative if your health care case may help in a drug study or if you had a severe adverse reaction to the medication. Your attending physician will contact you to obtain your verbal or written authorization prior to releasing your PHI when pertaining to research purposes.
h. We routinely share PHI with other doctors and pharmacists on your care management team for your continued care.

Any other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object. If you are not present or able to agree or object, than we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

1. **Others involved in your Health care** – We may disclose to a member of your family, a relative, a close friend or any other person you indentify, your PHI. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative,

   or any other person that is responsible for your care (including funeral homes) of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals in your health care.

Julian Ungar-Sargon, M.D., Ph.D.

123 S. McKinley Avenue
Rensselaer, IN 47978
219-866-7222
fax: 219-866-7001

130 Professional Ct. Ste. D
Lafayette, IN 47905
765-446-8888
fax: 765-446-8889

255 E 90th Dr, W3
Merrillville, IN 46410
219-756-0400
fax: 219-866-7001

2. **Emergencies** – In the event of an emergency treatment situation, we shall try to obtain your consent to use and disclose your PHI as soon as reasonably practical after the delivery of treatment. If the attending physician is required by law to treat you and he has attempted to obtain your consent but was unable to do so, he may still use or disclose your PHI information to treat you.
3. **Communication Barriers** – If the attending physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers, we may use and disclose your PHI if he determines, using professional judgment, that your intent is to provide consent.

We may use or disclose your PHI in the following situations without your consent or authorization:

1. **Required By Law** – the use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
2. **Public Health** – the disclosure will be made for the purposes of controlling disease, injury, or disability or if directed by the public health authority, to a foreign government agency that is collaborating with the public authority.
3. **Communicable Diseases** – if authorized by law, we may disclose your PHI to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
4. **Health Oversight** – We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies include government agencies that oversee the health case system, government benefit programs, other government regulatory programs and civil rights laws.
5. **Abuse or Neglect** – We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been the victim of abuse, neglect or domestic violence to the governmental agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
6. **Food and Drug Administration** – We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products, to enable product recalls; to make repairs or replacements, or conduct post marketing surveillance, as required.
7. **Legal Proceedings**
8. **Law Enforcement**
9. **Coroners, Funeral Directors, and Organ Donation** – We may disclose your PHI for identification purposes, determining cause of death or for coroner or medical examiner to perform other duties authorized by law.

Julian Ungar-Sargon, M.D., Ph.D.

123 S. McKinley Avenue
Rensselaer, IN 47978
219-866-7222
fax: 219-866-7001

130 Professional Ct. Ste. D
Lafayette, IN 47905
765-446-8888
fax: 765-446-8889

255 E 90th Dr, W3
Merrillville, IN 46410
219-756-0400
fax: 219-866-7001

NOTICE OF PRIVACY PRACTICES

10. **Research** – We may disclose your PHI when a research proposal has been reviewed by an institutional review board to ensure the privacy of your PHI.
11. **Criminal Activity**
12. **Military Activity and National Security**
13. **Worker's Compensation**
14. **Inmates** – We may disclose your PHI if you are an inmate of a correctional facility and your PHI was obtained in the course of providing care for you.
15. **Required Uses and Disclosures** – As required by the Secretary of the Dept. of Health and Human Services to investigate our compliance with the requirements of Section 164.500 et seq.

Your Rights:

You have the following rights with respect to your Protected Health Information, which you can exercise by presenting a completed **Patient's Authorization for Release of Protected Health Information** form to the Privacy Officer, **Michalene R. Yeoman:** (fees may be applicable per Indiana law related to medical record copying fees)

1. **The right of access to your Protected Health Information** which shall follow our established **Patient Right of Access to Protected Health Information Policy and Procedure** and **Minimum Necessary Policy.**
2. **The right to inspect and copy your protected health information**. Under the federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in a reasonable anticipation of or use in any civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
3. **The right to request a restriction of your protected health information. A Restricted Information Form needs to be filled out completely.** Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of the restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions wish with your attending physician.
4. **The right to request to receive confidential communications from us by alternative means or at an alternate location**. We may also condition this accommodation by asking you for information as to how payment will be handles or specification of an alternative address or other method of contact.
5. **The right to have your physician amends your protected health information**. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal

Julian Ungar-Sargon, M.D., Ph.D.
123 S. McKinley Avenue
Rensselaer, IN 47978
219-866-7222
fax: 219-866-7001

130 Professional Ct. Ste. D
Lafayette, IN 47905
765-446-8888
fax: 765-446-8889

255 E 90th Dr, W3
Merrillville, IN 46410
219-756-0400
fax: 219-866-7001

NOTICE OF PRIVACY PRACTICES

6. **The right to receive an accounting of certain disclosures we have made, if any, of your protected health information after April 14. 2003 and after January 1, 2007, the oldest date of medical records with our offices.**
7. **The right to obtain a paper copy of this notice from us upon request.**

____
Julian Y. Ungar-Sargon, M.D., Ph.D.
Owner, Governing Body Chairman

Date G.B. Approved: __________________
Date Presented at staff meeting: __________

Date Originated: 02.17.2008
Dates Revised: 08.02.2011 to add Patient Access Right to PHI, and all office locations
Date finalized for GB discussion: 08.02.2011