Central Washington Endocrine Center

111 S. 11th Ave, Suite 321 P (509) 577-4600 F (509) 577-4619

Dear New Patient:

Welcome to Central Washington Endocrine Center. You are scheduled for an appointment with

Gary L.Treece, M.D.

(Please arrive 20 minutes early so that we may complete your registration in time for your appointment)

On: ______________________________ At: ______________

Our office address:

111 S. 11th Ave, Suite 321
Yakima, WA 98902
(509) 577-4600

Enclosed you will find the forms we will need in order to set up your medical record account. We ask that you bring the completed forms to your first appointment.

In addition to these forms you will need to bring the following:

- **photo identification** and all **insurance cards or proof of coverage** for payment of charges. Without proper coverage you will be asked to pay at the time services are provided.
- We ask that you bring all of your **medications that you are taking in the bottles** to the appointment. If you are unable to keep this appointment, please call 48 hours in advance.

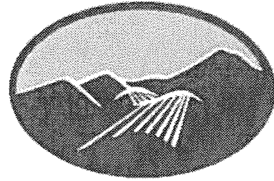
Referrals: If your insurance, healthy options, or basic health coverage requires an authorization from your primary care doctor, it is your responsibility to make sure that is in place for your appointment. Without the proper authorization number available you may be asked to reschedule the appointment or pay in advance for the services.

Payment: If your insurance plan includes a co-payment amount, we are required to collect this at the time of your appointment. You are responsible for payment of the services rendered by your Physician. As a courtesy to you, we will bill your Primary and Secondary insurance's.

We look forward to providing services to you and hope having this information will help speed up the process of getting you registered and seen by the provider.

If you have any questions or need to reschedule your appointment, please call us at ***(509) 577-4600.***

Thank you for choosing the Central Washington Medical Group for your medical needs. We look forward to providing you with great care.



Central Washington Medical Group

WELCOME TO THE CENTRAL WA ENDOCRINE CENTER(CWEC)!!

You have been referred by your primary care provider for further evaluation and treatment by Dr. Gary Treece of a suspected or previously diagnosed problem of the endocrine system of your body. If it is mutually agreed that you should require one or more follow-up visits here, you may be seen by one of Dr. Treece's professional assistants whom he has trained to help him to provide endocrine care to the hundreds of patients cared for by the CWEC. You may be cared for by **Glenda Petrie, Advanced Registered Nurse Practitioner and Certified Diabetes Educator**, or **Benjamin Rodriguez, Physician Assistant**. Although you may not see Dr. Treece during your visit with one of his assistants, rest assured that he is supervising your care and will personally contribute to your care when and if necessary. The Endocrine Center Team (as we like to think of ourselves) is dedicated to consistently provide competent and compassionate care to its patients. Your cooperation and participation in the above outlined Endocrine Team Patient Care Plan is greatly appreciated now and in the future.

Gary Treece MD, FACP, FACE

Glenda Petrie, ARNP, CDE

Benjamin Rodriguez, PA-C

Central Washington Medical Group

Patient Name: ______________________________

Date of Birth: ______________________________

Primary Care Provider: ______________________

Health History

Symptoms Check (✓) symptoms you currently have or have had in the past year

GENERAL

- [ ] Chills
- [ ] Depression
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Forgetfulness
- [ ] Headache
- [ ] Loss of sleep
- [ ] Loss of weight
- [ ] Nervousness
- [ ] Numbness
- [ ] Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- [ ] Arms
- [ ] Back
- [ ] Feet
- [ ] Hands
- [ ] Hips
- [ ] Legs
- [ ] Neck
- [ ] Shoulders

GENITO-URINARY

- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Lack of bladder control
- [ ] Painful urination

GASTROINTESTINAL

- [ ] Appetite poor
- [ ] Bloating
- [ ] Bowel changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive hunger
- [ ] Excessive thirst
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Nausea
- [ ] Rectal bleeding
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Vomiting blood

CARDIOVASCULAR

- [ ] Chest pain
- [ ] High blood pressure
- [ ] Irregular heart beat
- [ ] Low blood pressure
- [ ] Poor circulation
- [ ] Rapid heart beat
- [ ] Swelling of ankles
- [ ] Varicose veins

EYE, EAR, NOSE, THROAT

- [ ] Bleeding gums
- [ ] Blurred vision
- [ ] Crossed eyes
- [ ] Difficulty swallowing
- [ ] Double vision
- [ ] Earache
- [ ] Ear discharge
- [ ] Hay fever
- [ ] Hoarseness
- [ ] Loss of hearing
- [ ] Nosebleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Vision-Flashes
- [ ] Vision-Halos

SKIN

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scars
- [ ] Sore that will not heal

MEN only

- [ ] Breast lump
- [ ] Erectile difficulties
- [ ] Lump in testicles
- [ ] Penis discharge
- [ ] Sore on penis
- [ ] Other:

WOMEN only

- [ ] Abnormal pap smear
- [ ] Bleeding between periods
- [ ] Breast lump
- [ ] Extreme menstrual pain
- [ ] Hot flashes
- [ ] Nipple discharge
- [ ] Painful intercourse
- [ ] Vaginal discharge
- [ ] Other:

Date of last Menstrual period: ____________

Date of last pap: ____________

Have you had a mammogram? __

If yes, when: ____________

Are you pregnant? ____________

Number of children? __________

Medications List medications you are currently taking

Medications

Allergies To medications or substances

Allergy	Reaction

Social History	
Do you smoke?	Yes / no
How much?	
Since Age?	
Chewing tobacco?	Yes / no
Alcohol intake:	None Occasional Moderate Heavy
Illicit Drugs?	Yes / no
Occupation:	
Marital status:	
Number of Children:	
Live alone or with others?	
Education:	Less than 8th grade / 8 / 9 / 10 / 11 / 12 / 2 year college / 4 year college / post graduate
Diet: regular/ vegeterian/ vegan/ gluten free/ specific/ carbohydrate/ cardiac/ diabetic	
Caffeine intake:	none / occasional / moderate / heavy
exercise level:	none / occasional / moderate / heavy
Sexual orientation:	heterosexual / homosexual / bisexual
General stress level:	low / medium / high
Guns in home?	Yes / No
Seat belts used routinely?	Yes / no
Sunscrean used routinely?	Yes / no
Smoke alarm in home?	Yes / no
Performs monthly self breast exams?	Yes / no
Presence of domestic violence?	Yes / no

Preferred Pharmacy: ____

Preferred Lab: ____

Past Medical History

Condition	Yes / No
Anemia	Yes / No
Anxiety/Depression	Yes / No
Aortic Aneurysm	Yes / No
Asthma	Yes / No
Back Problems	Yes / No
Blood Clots	Yes / No
Blood Diseases	Yes / No
COPD	Yes / No
CVA	Yes / No
Cancer	Yes / No
Deep Vein	Yes / No
Depression	Yes / No
Diabetes	Yes / No
Diverticulitis/	Yes / No
GERD/Reflux	Yes / No
Gout	Yes / No
HIV or AIDS	Yes / No
Heart Attack (MI)	Yes / No
Heart Murmur	Yes / No
Hepatitis	Yes / No
High Blood Pressure	Yes / No
High Cholesterol	Yes / No
Hyperlipidemia	Yes / No
Hypertension	Yes / No
Hyperthyroidism	Yes / No
Hypothyroidism	Yes / No
Illicit Drugs	Yes / No
Kidney Stones	Yes / No
Lupus	Yes / No
Mammograms	Yes / No
Migraines	Yes / No
Narcotics/Pain Meds	Yes / No
Neurologic Disorder	Yes / No
Obesity	Yes / No
Organ Transplant	Yes / No
Osteoporosis	Yes / No
Ovarian Cancer	Yes / No
Pulmonary	Yes / No
Reflux/ GERD	Yes / No
Seizures	Yes / No
Seizures/Epilepsy	Yes / No
Sleep Disorder	Yes / No
Stroke	Yes / No
Thyroid Disease	Yes / No
Tobacco Abuse	Yes / No

Other:

Family History:

Relationship	Alive?	Medical problems:
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	

Surgical History

Please list any surgeries you have had:

Date:	Surgery performed:

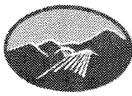
Pregnancy History

Year of Birth	Sex of Child	Complications if any

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____________________ Date ________

Reviewed By ____________________ Date ________



Central Washington Internal Medicine & Endocrine Center
REGISTRATION INFORMATION
(Please Print)

Patient Information

Patient Name: ______________________ DOB: ____________ Sex: ☐ Male ☐ Female

Home Phone: ______________________ Cell Phone: ______________________

Mailing Address: ______________ City: __________ State: ______ Zip Code: ________

Social Security #: ______________________ Email Address: ______________________

Patient Employer: ______________________ Work Phone: ______________________

Referring Physician: ______________________ Primary Physician: ______________________

Emergency Contact: ______________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Insurance Information

Policy Holder Information: (If different than patient)

Name: ______________________ Social Security #: ______________________

Birth Date: ____________ Employer: ______________________ Work Phone: ____________

Job Related: ☐ Yes ☐ No Claim #: ______________________ Date of Injury: ______________

Motor Vehicle Accident: ☐ Yes ☐ No Claim #: ______________ Date of Injury: ______________

Insurance: ______________Claims Manager: ____________ Phone: ____________

FINANCIAL POLICY

Ahtanum Ridge Family Medicine Central Washington Internal Medicine & Endocrine Center Central Washington Neurosciences Central Valley Vascular Center Central Washington Orthopedic Surgeons Central Washington Rehabilitation Clinic Selah Clinic Summitview Family Medicine Terrace Heights Family Physicians

We are committed to fiscal responsibility and want to inform you of our billing practices and expectations.

- Co-pays, co-insurance and deductibles must be paid at time of service.
- We Accept CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS & DEBIT CARDS
- Insurances accepted and filed as a courtesy, however patient holds ultimate responsibility for co-pays, coinsurance, and any service not covered by their plan.
- We accept Worker's Compensation Claims and Auto Insurance Claims.
- Deposits are required prior to services for all Private Pay accounts.
- All Payment Plan requests must go through an approval process. The minimum monthly payments are based on your outstanding balance.
- A fee of $27.00 will be charged on all returned checks. Delinquent accounts will be placed in collections.

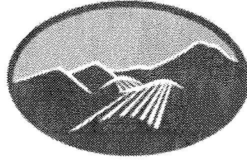
I HAVE READ THE FINANCIAL POLICY AND HAVE ACCEPTED ITS TERMS.

Signature: ______________________ Date: ______________

(If patient is unable to sign, please indicate reason): ______________________

______________________ ______________________

Signature of person authorized to consent for patient Witness



General Consent to Treat/
Acknowledgement of Benefits Release

The following are the conditions for services provided by **Central Washington Medical Group** for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by **Central Washington Medical Group** and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and **Central Washington Medical Group**. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that **Central Washington Medical Group** can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

____

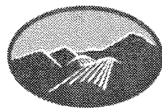
Patient Name

_________________   ______________________________________

Date   **Signature of Patient/(Parent, Guardian or Legally Authorized Representative)**

_________________   ______________________________________

Date   **Signature of Witness**



Ahtanum Ridge Family Medicine
Central Washington Internal Medicine
Central Washington Orthopedic Surgeons
Central Washington Surgical Associates
Terrace Heights Family Physicians

Central Washington Endocrine Center
Central Washington Occupational Medicine
Central Washington Rehabilitation Clinic
Summitview Family Physicians

Authorization to Release Medical Information with Designated Individuals

Do you give your Provider of Central Washington Medical Group permission to discuss and/or release your medical information with family members/caregiver?

☐ **NO** ☐ **YES** *If yes, please provide complete information below*

Name: ______________________ Relationship: ______________________

DOB: ______________________ Phone Number: ______________________

Name: ______________________ Relationship: ______________________

DOB: ______________________ Phone Number: ______________________

Name: ______________________ Relationship: ______________________

DOB: ______________________ Phone Number: ______________________

If you have an answering machine at home may we leave messages containing medical information, such as scheduling and prescription issues?

☐ **NO** ☐ **YES**

X ______________________ ______________________
Signature of Patient Date

____
Print First and Last Name

X ______________________ ______________________
Signature of Witness Date

This authorization may be revoked in writing at any time. However, a revocation would not effect any actions already taken by Central Washington Medical Group based upon this authorization. Proof of identification will be needed for verification.

CW Internal Medicine & Endocrine Center
PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: ______________________________

Social Security Number: ____________________

Notice Version (Date): ____________________

Acknowledgement of receipt of Privacy Practices Notice

I, ______________________________, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: ______________________ Date: ______________________

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: ______________________

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: ______________________

____

____

Describe the reason why the individual would not sign this form: ______________________

____

____

SIGNATURE: (Hospital Representative)

I attest that the above information is correct.

Signature: ______________________ Date: ______________________

Print name: ______________________ Title: ______________________

Include this acknowledgement form in the individual's records.

CENTRAL WASHINGTON MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

Version Date: September 23, 2013

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

If you have any questions about this notice please contact our privacy officer at: (509) 575-5018

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice version 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 medical information that we maintain, including medical 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.

Who Will Follow This Notice?

This notice describes our facility's practices and those participants listed below in our organized health care arrangement. As such, we may share your medical information and the medical information of others we service with each other as needed for treatment, payment or health care operations relating to our organized health care arrangement.

This notice does not imply any joint venture or any other special association or legal relationship between the hospital and its medical staff. This notice is an administrative tool permitted by federal law allowing the hospital and medical staff to tell you about common privacy practices.

Along with the hospital, the following participate in our organized health care arrangement:

- Members of our medical staff and their employees or workforce who provide services or support to the physician at the hospital.
- Our employed physicians and their office staff.

Uses and Disclosures of Medical Information

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

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal and state Privacy Rules so they can obtain payment.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. These uses are necessary to make sure that all our patients receive quality care.

Some examples are:

- Review of our treatment or services to evaluate the performance of our staff providing your care;
- sending you a satisfaction survey;
- review of information about many of our patients to determine if additional services should be added or perhaps are no longer needed;
- information may be given to our doctors, nurses, medical and health care students, and other personnel to be used for education and learning purposes;
- we may remove information that identifies you from the medical information so others may use it for studies in health care delivery without learning who the patients are; and
- we may disclose your medical information to another provider who has a relationship with you and is subject to the same Privacy rules, for their health care operation purposes.

On Your Authorization: You may give us written authorization to use your medical 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 medical information for any reason except those described in this notice.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the facility.

To Your Family and Friends: Unless you object, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of medical information.

Hospital Directory: We may use your name, your location in our facility, your general medical condition, and your religious affiliation in our facility directories. We will disclose this information to members of the clergy and, except for religious affiliation, to other persons who ask for you by name. We will provide you with an opportunity to restrict or prohibit some or all disclosures for facility directories unless emergency circumstances prevent your opportunity to object. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so your family can be notified about your condition and location.

By Law or Special Circumstances: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- In response to court and administrative orders and other lawful processes;

- to law enforcement officials after receiving subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

Health Related Benefits and Services: We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Use and Disclosure of Certain Types of Medical Information. For certain types of medical information we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your medical information:

HIV Information. We may not disclose HIV information unless required by law, pursuant to an authorization or the disclosure is to you or your personal representative; to pre-hospital transport agencies and emergency personnel of a patient's condition; to funeral directors; to persons whom a physician believes is in a foreseeable, real or probable risk of HIV infection; to physicians involved in the care of the individual; in accordance with appropriate subpoena procedures; or to other persons as may be required by law.

Sexually Transmitted Disease Information. We may not disclose sexually transmitted disease information unless required by law, pursuant to an authorization or to you or your personal representative.

Alcohol and Drug Abuse Information. We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or pursuant to an authorization or as may otherwise be allowed by law.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy: You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. 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 a fee for copying and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, for six (6) years from the date of your request. You must make a request in writing to request a listing of disclosures. You may obtain a form to request the accounting by using the contact information at the end of this notice. 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. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place certain restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions except in limited circumstances described below, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information by using the contact information listed at the end of this notice. We will not be bound to the restrictions unless our agreement is signed by you and the appropriate hospital representative. We will grant a request for restriction of disclosure of your protected health information to your health insurer if three conditions are met: (1) the reason we would disclose to the insurer is for payment or health care operations, (2) the disclosure is not required by law, and (3) you or another person has paid us in full for the health care item or service.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. You may obtain a form to request alternative communications by using the contact information listed at the end of this notice. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice. We may deny your request if we did not create the information you want amended and the individual who provided the information remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

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. Please contact us using the information listed at the end of this notice to obtain 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 using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical 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 medical 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: **Privacy Officer**

Telephone: 509-575-5018

Address: 110 S. 9TH AVENUE

YAKIMA, WA 98908

Thank you.