COASTAL MAINE
INTERNAL MEDICINE

Dear Patient:

Welcome to Coastal Maine Internal Medicine! We look forward to helping you in your journey to better health. **Care with our office begins at your first appointment.** Our office is currently open Monday, Tuesday, Wednesday and Friday 7:30 – 4:00. We encourage you to call us at 207-230-8220 before stopping in to ensure the office is open.

Our office provides:

Personalized Care

- We are here to listen to you and answer your questions to help you fully understand your treatment options
- We'll help guide and support you anytime you need to see specialists or providers outside the office, including behavioral health
- We'll ask for your feedback about the office, and how we're doing in taking care of you
- We'll connect you with community resources and care management

Better Access

- As always, we will do our best to provide you with same day or next day appointments with Dr. Schenk
- We will return your call and answer questions the same day during normal business hours.
- When the office is closed, call our number to reach the answering system to leave a message or get connected with the physician for an urgent health issue when necessary.
- Easy access to your personal health information via our patient portal where you can make appointments, send non-urgent messages and renew most prescriptions.

What you can do:

- Ask questions. Bring a list to your appointment
- Bring a list of your medications to your appointment
- Keep your healthcare team informed when you visit another office
- Give us feedback during your appointment

If you run out of a medicine or need a referral before your first visit, please contact your previous physician. We cannot prescribe medications or refer you to specialists until you have your first appointment. If you have any questions, please call the office at 207-230-8220. We look forward to working with you to a healthier you!

Sincerely,

Coastal Maine Internal Medicine

COASTAL MAINE INTERNAL MEDICINE
DR. ERIC SCHENK
247 COMMERCIAL STREET, STE. D • ROCKPORT, MAINE • 04856
PHONE: 207-230-8220 FAX: 855-233-9889

First Name: _____ Nickname: _____ M.I.: ____ Last Name: _____

Birth Date: _____ Age: _____ SS#:_____ Sex: ☐ Female ☐ Male

Mailing Address: _____ City: _____ State: _____ Zip:_____

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

Email address (required for patient portal access): _____

Best way for us to contact you (**pick only ONE**): ☐ Home ☐ Cell ☐ Work ☐ Patient portal

Have you been COVID vaccinated? ☐ Yes ☐ No

Employer: _____ Occupation: _____

What pharmacy do you use? Name _____ City: _____

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other

Race (select one): ☐Caucasian (white) ☐Asian ☐American Indian ☐Black ☐Hispanic ☐Other

Ethnicity (select one): ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Emergency Contact:

Name: _____ Relation: _____ Home: _____ Cell: _____

What are your medical problems? _____

_____

What other concerns would you like to discuss with the doctor today if there is time?

_____

When were you last seen by a physician? _____

Who cared for you? _____

Who referred you to this office? _____

Please list the medications that you take and the dose:

Medication:	Dose:	Medication:	Dose:

Do you have any drug allergies?

☐ No ☐ Yes

If Yes, please list allergy and reaction:

Allergy:	Reaction:

Please list any surgeries you have had:

Surgery:	Date:

Family History

	PLEASE CHECK ONE			
	Alive	Deceased	Age	Health Problems
Father				
Mother				
Brother				
Sister				
Son				
Daughter				

Are your grandparents living? _____

Authorization for Use or Disclosure of Medical Record Information

COASTAL MAINE
INTERNAL MEDICINE

Eric R. Schenk, D.O.
247 Commercial Street, Ste D
Rockport, Maine 04856
207-230-8220 phone 855-233-9889 fax

Patient Information Yellow highlight indicates MINIMUM information required

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Obtain Information

I hereby authorize Coastal Maine Internal Medicine to obtain all medical records from:

Name/Facility: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Purpose of request: ☐ Personal ☐ Continuing Care ☐ Legal/Insurance ☐ Transfer of care ☐ Other _____

PLEASE SEND RECORDS VIA FAX (855-233-9889) OR ON A CD

Information to be Released - include dates of treatment if applicable

Complete medical record Date(s) of Treatment:_____

Authorization for Release of Statutorily Protected Information

I DO authorize HIV Tests & Related Information _____ I DO NOT authorize

I DO authorize Alcohol and/or Substance Abuse _____ I DO NOT authorize

I DO authorize mental health diagnosis or treatment _____ I DO NOT authorize

I DO NOT want to review mental health information prior to being sent _____ Yes, I want to review

I understand that the information release pursuant to this Authorization may be re-disclosed by the receiving institution or individuals to other individuals or organizations that are not subject to privacy protection laws. Coastal Maine Internal Medicine will not condition treatment on payment of the provision of this Authorization.

_____ _____
Patient's Signature Date *

_____ _____
Parent/Legally Recognized Representative Signature * * Date*

_____ _____
Witness Date *

* This authorization is valid for 120 days (60 days for alcohol/drug abuse treatment) unless you specify otherwise: _____. You may revoke this Authorization at any time by providing a written statement to our office, except to the extent that we have already completed action on it.
* * By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: _____.

Authorization for Use or Disclosure of Medical Record Information

COASTAL MAINE
INTERNAL MEDICINE

Eric R. Schenk, D.O.
247 Commercial Street, Ste. D
Rockport, Maine 04856
207-230-8220 phone 855-233-9889 fax

Patient Information Yellow highlight indicates MINIMUM information required

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Obtain Information

I hereby authorize Coastal Maine Internal Medicine to obtain all medical records from:

Name/Facility: Pen Bay Medical Center Address: 6 Glen Cove Drive

City: Rockport State: ME Zip: 04856

Purpose of request: ☐ Personal ☑ Continuing Care ☐ Legal/Insurance ☐ Transfer of care ☐ Other _____

Information to be Released - include dates of treatment if applicable

Complete medical record Date(s) of Treatment: All

Authorization for Release of Statutorily Protected Information

I DO authorize HIV Tests & Related Information _____ I DO NOT authorize

I DO authorize Alcohol and/or Substance Abuse _____ I DO NOT authorize

I DO authorize mental health diagnosis or treatment _____ I DO NOT authorize

I DO NOT want to review mental health information prior to being sent _____ Yes, I want to review

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Parent/Legally Recognized Representative Signature * * Date*

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Witness Date *

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* * By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: _____.

Advanced Directive

Do you have an advanced directive? Yes/No

Education and Occupation

What is the highest grade or level of school you have completed or the highest degree you have received? _____

Did you complete a degree program? Yes/No

Are you currently employed? Yes/No
If yes, who is your employer? _____
What is your occupation? _____
Are there any occupational health risks where you work? _____

Marriage and Sexuality

What is your relationship status?
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Domestic Partner

Are you sexually active? Yes/No
How many children do you have? _____

Diet and Exercise

What type of diet are you following?
- ☐ Regular
- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten Free
- ☐ Low Carb
- ☐ Cardiac
- ☐ Diabetic

Do you have any dietary restrictions? Yes/No
If so, what are they? _____

What is your exercise level?

- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy

What types of sporting activities do you participate in? _____

Substance Use

Do you or have you ever smoked tobacco?

- ☐ Never smoker
- ☐ Former smoker
- ☐ Current every day smoker
- ☐ Current some days smoker

If current or former smoker:
How many years have you smoked tobacco? _____
How much tobacco do/did you smoke?

- ☐ 1 pack per week
- ☐ 2 packs per week
- ☐ ¼ pack per day
- ☐ ½ pack per day
- ☐ 1 pack per day
- ☐ 2 packs per day
- ☐ 3 or more packs per day

If former smoker:
What year did you quit smoking? _____

Do you or have you ever used any other forms of tobacco or nicotine? Yes/No

Do you or have you ever used e-cigarettes or vape?

- ☐ Never used electronic cigarettes
- ☐ Former user of electronic cigarettes
- ☐ Current user of electronic cigarettes

Do you or have you ever used smokeless tobacco?

- ☐ Never used smokeless tobacco
- ☐ Current snuff user
- ☐ Currently chews tobacco
- ☐ Currently uses moist powdered tobacco

If you chew tobacco, how much do you chew?

- ☐ 1 per day
- ☐ 2-4 per day
- ☐ 5+ per day

What is your level of alcohol consumption?

- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy

How many times per week do you consume alcohol?

- ☐ 1-2 times per week
- ☐ 3-4 times per week
- ☐ 5-7 times per week

How many days in the past year have you consumed 4 or more drinks? _____

Do you use any illicit or recreational drugs? Yes/No

What is your level of caffeine consumption?

- ☐ None
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy

Activities of Daily Living

Are you able to care for yourself? Yes/No
Are you blind or do you have difficulty seeing? Yes/No
Are you deaf or do you have serious difficulty hearing? Yes/No
Do you have difficulty concentrating, remembering or making decisions? Yes/No
Do you have difficulty walking or climbing stairs? Yes/No
Do you have difficulty dressing or bathing? Yes/No
Do you have difficulty doing errands alone? Yes/No
Do you have transportation difficulties? Yes/No

Which of your hands is dominant?

- ☐ Right
- ☐ Left
- ☐ Bilateral

Do you use a seatbelt routinely? Yes/No

Home and Environment

Where do you live?

- ☐ Single-level house
- ☐ Multi-level house
- ☐ Apartment
- ☐ Trailer
- ☐ Condo
- ☐ Other

Do you have any pets? Yes/No
If yes, what kind of pets do you have? _____

Do you have a basement? Yes/No

Do you have smoke and carbon monoxide detectors in your home? Yes/No

Are there any smokers in your house? Yes/No

Are there any guns present in your home? Yes/No

Do you use sunscreen routinely? Yes/No

Do you see your dentist regularly Yes/No If yes, who? _____

Do you see your eye doctor regularly? Yes/No If yes, who? _____

What is your religious affiliation? _____

Do you have a history of Miltary service? Yes/No
If yes, what branch and what years? _____

Have you ever traveled to a foreign country? Yes/No
If yes, what countries? _____

List your hobbies: _____

Patient Name: _____ Date: _____ What is the main reason for today's visit? _____
Have you had any new problems since your last visit? _____ Other concerns would you like to discuss if there is time_____

New Symptoms - Check all conditions that you have had in the past **MONTH**

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Headaches
- ☐ Fatigue
- ☐ Difficulty sleeping

Skin
- ☐ Dry skin
- ☐ Itching skin
- ☐ Tattoos
- ☐ Rash
- ☐ Psoriasis
- ☐ Cuts
- ☐ Skin infection
- ☐ Moles
- ☐ Other skin concerns: _____

Eyes
- ☐ Blurry vision
- ☐ Itching eyes
- ☐ Double vision
- ☐ Loss of vision
- ☐ Wear glasses

Ears/Nose /Mouth
- ☐ Ringing in the ears
- ☐ Loss of hearing
- ☐ Ear pain
- ☐ Ear drainage
- ☐ Runny nose
- ☐ Sinus congestion
- ☐ Sinus pressure
- ☐ Bleeding from nose
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Dentures
- ☐ Trouble speaking
- ☐ Trouble chewing your food
- ☐ Mouth sores

Respiratory
- ☐ Asthma
- ☐ Cough
- ☐ Wheeze
- ☐ Painful breathing
- ☐ Exposure to asbestos
- ☐ Other lung disease:_____

Cardiovascular
- ☐ High blood pressure
- ☐ Past heart attack
- ☐ Leg pain when walking
- ☐ Shortness of breath with activity
- ☐ Heart murmur
- ☐ Chest tightness
- ☐ Chest pain (angina)
- ☐ Sweating
- ☐ Dizziness
- ☐ Heart surgery
- ☐ Other heart disease: _____

Gastrointestinal
- ☐ Heart burn
- ☐ Nausea after eating
- ☐ Abdominal pain after eating
- ☐ Vomit
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Flatulence

Genital – Male
- ☐ Pain with intercourse
- ☐ Difficulty with erection
- ☐ Difficulty with ejaculation
- ☐ Sexual difficulties
- ☐ Pain in Testicles

Genital – Female
- ☐ Painful intercourse
- ☐ Last period: ___/___/___
- ☐ Onset of period: ___/___/___
- ☐ Vaginal discharge
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Menopause
- ☐ Sexual difficulties
- ☐ Are you sexually active? Yes / No

Urinary
- ☐ Burning on urination
- ☐ Pain on urination
- ☐ Blood in urine
- ☐ Decreased urine output
- ☐ Urinary tract infection
- ☐ Urinating at night
- ☐ Incontinence

Musculoskeletal
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle spasms

Musculoskeletal (cont)
- ☐ Arthritis
- ☐ Decreased range of motion
- ☐ Knee pain
- ☐ Hand pain
- ☐ Hip pain
- ☐ Shoulder pain

Neurological
- ☐ Numbness
- ☐ Tingling
- ☐ Seizure
- ☐ Migraines
- ☐ Past stroke
- ☐ Other Neurological concern:_____

Blood Systems
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Take aspirin

Endocrine
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Excessive hunger
- ☐ Intolerance to cold
- ☐ Intolerance to heat
- ☐ Thyroid disorder
- ☐ Diabetes

Allergic/Immune System
- ☐ Environmental allergies
- ☐ Hives
- ☐ Throat swelling
- ☐ Allergy to bee sting
- ☐ Exposure to Tuberculosis
- ☐ Exposure to HIV
- Exposure to Hepatitis

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Agitation
- ☐ Treatment by a Psychiatrist of any kind
- ☐ Mood swings
- ☐ Hallucination

☐ Other
Please list other symptoms not on the sheet

_____
_____
_____

Please check all that apply:

- ☐ I have a prescription that needs to be refilled – Pharmacy _____
- ☐ I need a work excuse
- ☐ I need a referral for my insurance company
- ☐ I need the attached form filled out

COASTAL MAINE
INTERNAL MEDICINE

PLEASE READ, SIGN AND DATE THE FOLLOWING FINANCIAL POLICY AGREEMENT

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience we accept Visa and MasterCard. Returned checks will be charged a $20.00 processing fee.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. As a service to you, we will bill those plans with whom we have an agreement and will collect any required co-payments at the time of service. The co-payment will be collected when you arrive for your appointment. If your health plan determines a service is "not covered" you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will provide a bill which you may submit. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

AUTOMOBILE ACCIDENTS AND WORK-RELATED VISITS

If your visit relates to an automobile accident you will be expected to pay for your care and treatment at the time of service. We will submit the claim for you providing we participate with your insurance and you provide us with a letter from your auto insurance stating you have no medical coverage.

AGREEMENT

I have read and understand the financial policy of Coastal Maine Internal Medicine (CMIM) and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by CMIM.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Eric Schenk all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ Yes ____ NO I allow CMIM to call me, send automated calls and/or text messages
____ Yes ____ NO I allow CMIM to electronically communicate with my chosen pharmacy
____ Yes ____ NO I have received a copy of the notice of privacy practices

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Please Print the Name of the Patient Relationship to Patient

COASTAL MAINE
INTERNAL MEDICINE

The following is a summary of our office policies. Please read them carefully and keep this information for future reference. We reserve the right to make changes to these policies at any time.

Appointments
Appointments can be made during normal business hours by calling 207-230-8220. Please arrive **10 minutes PRIOR to your scheduled appointment time** to allow us time to check you in**.** Patients arriving 5 minutes or more **after** their scheduled appointment time will be required to re-schedule so as to not delay patients who do arrive on time.

Follow Up Appointments
We provide high quality healthcare and in order to do so, we expect that our patients are willing to be seen, at a minimum, once per year. If you have chronic medical conditions you should expect to be seen 2-4 times per year for regular follow up. If you are not willing to comply with our suggested follow up recommendations, we invite you to find a medical office that will allow you to dictate the quality of care you receive.

Cancellations
When you must cancel or change your appointment, please call at the earliest possible time to let us know. We need at least 24 hours notice. On your second no-show occurrence, there will be a $50 charge to your account. This fee is not covered by insurance, and must be paid prior to your next appointment. We reserve the right to terminate our relationship as a result of missed appointments and late cancellations. If you miss 3 visits in a 12 month period without calling 24 hours in advance you will be asked to find a new physician.

Our Hours
Our office is open Monday, Tuesday, Wednesday and Friday 8:00 to 4:30. We are closed all day on Thursdays.

Prescriptions
We want you to refill prescriptions at the time of your doctor's visit. If you need a refill on a prescription and you do not have an appointment prior to running out of your medication, please **contact your pharmacy**. Your pharmacist will send an electronic refill request to us. Please allow **at least 48 hours for all refill requests to be processed**. During regular business hours we are caring for our patients who have scheduled appointments and try to take care of refill requests during our lunch hour and at the end of the day. Please do not phone us to see if the prescription has been sent. If you have requested the refill request from your pharmacy and have allowed **at least 48 hours** then you may contact the pharmacy to verify that it has been filled prior to picking it up. It is important that you plan ahead so that no delays occur in taking your regularly scheduled medications.

Narcotics Policy
We do not refill narcotics at the new patient appointment. If you do require narcotics for pain, you will be required to sign a medication use agreement prior to receiving a prescription.

DR. ERIC SCHENK
COASTAL MAINE INTERNAL MEDICINE
247 COMMERCIAL STREET, STE D • ROCKPORT, MAINE • 04856
PHONE: 207-230-8220 FAX: 855-233-9889

COASTAL MAINE
INTERNAL MEDICINE

Treatment of Office Staff
We understand that you come to us when you are not feeling well. We do, however, expect you to treat us with dignity and respect as we do our best to help you. We work very hard on a daily basis to help our patients. If you are unkind or demeaning to the office staff in any way, this office will not be a good fit for you and we will invite you to find a new physician.

Insurance
Most insurance policies require the patient to pay a percentage of each office visit along with a yearly deductible. It is important that you bring your insurance card and co-payment amount or deductible to each visit as well as be aware of your responsibility. We will submit the claims to the insurance company for you.

Medicare Replacement Plans
We participate with SOME Medicare replacement plans. If you establish with this practice while you have original Medicare and switch to a Medicare Replacement Plan, please check with us first to ensure we participate. Once you switch to a replacement plan that we do not participate with, you will not be able to receive services in our office and you would have to find a new physician.

Payment
We expect all of our patients to be responsible for keeping their accounts with us current. If you have a question about your bill, please feel free to call our office at 207-230-8220. If you do not have healthcare insurance you are responsible for paying the balance in full at each visit. Returned checks will be assessed a $20.00 fee and payment via cash or credit will be required at future visits.

Records Requests
Usually there is no change for medical records if your account is in good standing. If your account is not in good standing, a fee will be assessed.

Telephone Calls
We want you to feel free to call the office during regular office hours if there are any questions regarding your condition, medications or prescription refills. The doctor does not routinely accept telephone calls during office hours as he is busy seeing his scheduled patients. The office staff has been trained to answer many of your questions and will consult with the physician if necessary and will then return your call. All urgent phone calls will be responded to on the same day and any non-urgent call will be returned within 24 hours.

We are happy that you chose us for you healthcare needs and we look forward to serving you.

Please sign below to verify that you have read these policies and agree to abide by them:

_____	_____	_____
Patient Signature	Patient Name (Printed)	Date

DR. ERIC SCHENK
COASTAL MAINE INTERNAL MEDICINE
247 COMMERCIAL STREET, STE D • ROCKPORT, MAINE • 04856
PHONE: 207-230-8220 FAX: 855-233-9889

Notice of Privacy Practices

_____

Coastal Maine Internal Medicine

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used.

HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

· Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.

· Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

· Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

· The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

· Most uses and disclosure of psychotherapy notes;

· Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

· Disclosures that constitute a sale of PHI under HIPAA; and

· Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

· The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

· The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.

· The right to inspect and copy your PHI.

· The right to amend your PHI.

· The right to receive an accounting of disclosures of your PHI.

· The right to obtain a paper copy of this notice from us upon request.

· The right to be advised of your unprotected PHI is intentionally or unintentionally disclosed.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.
This notice if effective as of 01/01/14 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. Feel free to contact the Practice Compliance Officer (Melissa, 230-8220) for more information, in person or in writing.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Coastal Maine Internal Medicine

I am a patient of Dr. Eric Schenk. I hereby acknowledge receipt of Coastal Maine Internal Medicine's Notice of Privacy Practices.

Name: _____
(please print)

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____. I hereby acknowledge receipt of
(patient name)
Coastal Maine Internal Medicine's Notice of Privacy Practices with respect to the patient.

Name: _____
(please print)

Relationship to Patient (check one): ☐ Parent ☐ Guardian

Signature:_____

Date: _____