MICHAEL H. FRITSCH, M.D., F.A.C.S, PROFESSOR
OTOLOGY/NEUROTOLOGY
9002 N. MERIDIAN STREET, SUITE 204
INDIANAPOLIS, IN 46260

PATIENT INFORMATION: (PLEASE PRINT)

PATIENT'S NAME:

Last:_____ **First:**_____ **Middle:**_____

Date of Birth:_____ **Age:**_____ **Sex:** M F **Marital Status:** M S W D

Address:_____ **City:**_____

State:____ **Zip Code:**_____ **Home Phone #:**_____ **Cell Phone #:**_____

Social Security #:_____ **E-mail Address:**_____

Language:_____

Race: (CHOOSE ONE) American Indian Asian Asian Indian Black/African American European Filipino Japanese Korean Native Hawaiian/Pacific Islander White Other

Ethnicity: (CHOOSE ONE) Central American Cuban Dominican Hispanic/Latino Latin American Mexican Not Hispanic or Latino Puerto Rican South American Spaniard

Employer:_____ **Work Phone #:**_____

Contact Preference: Home Phone Work Phone Cell Phone Postal Mail

SPOUSE'S NAME:

Last:_____ **First:**_____ **Middle:**_____

Date of Birth:_____ **Social Security #:**_____

Home Phone #:_____ **Cell Phone #:**_____

Employer:_____ **Work Phone #:**_____

INSURANCE INFORMATION:

PRIMARY:

Member's Name:_____ **Name of Insurance:**_____

ID #:_____ **Group #:**_____

Relation to Patient:_____ **Specialist Co-Pay Amount:**_____

Type of Insurance: HMO PPO POS Indemnity Medicare Supplement Worker's Comp Other

SECONDARY:

Member's Name:_____ **Name of Insurance:**_____

ID #:_____ **Group #:**_____

Relation to Patient:_____ **Specialist Co-Pay Amount:**_____

Type of Insurance: HMO PPO POS Indemnity Medicare Supplement Worker's Comp Other

MEDICAID:

Medicaid #:_____ **Effective Date:**_____

Patient Name as on Card:_____ **County:** _____

REFFERING DOCTOR AND FAMILY DOCTOR:

Name of Referring Doctor:_____ **Phone #:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Name of Family Doctor:_____ **Phone #:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Name of Preferred Pharmacy:_____ **Phone #:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

How did you hear about us?

Physician Advertising Hospital Phone Book Internet Patient:_____ Other:_____

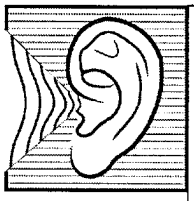
May we send you an appointment reminder postcard? YES NO Initial:_____

ALL PROFESSIONAL SERVICES RENEDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE DR. MICHAEL H. FRITSCH TO FURNISH INFORMATION TO INSURANCE CARRIERS INCLUDING MEDICARE/MEDICAID CONCERNING MY ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO DR. MICHAEL H. FRITSCH ALL PAYMENTS INCLUDING MEDICARE/MEDICAID AND MEDIGAP FOR MEDICAL SERVICES RENDERED TO ME OR FOR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Date:_____ **Signature:**_____



MICHAEL H. FRITSCH, M.D., F.A.C.S, PROFESSOR
OTOLOGY/NEUROTOLOGY
9002 N. MERIDIAN STREET, SUITE 204
INDIANAPOLIS, IN 46260

PATIENT HEALTH HISTORY

Date:_____

Please read and answer ALL of the following questions below. This will assist your healthcare team in providing optimal medical care. Thank you

Name of Patient:_____ **Date of Birth:**_____ **Age:**_____

1. Why are **you the patient** seeing Dr. Fritsch today? _____
   _____

2. Do other family members have the same or a related problem? **YES** or **NO**
   If you answer **YES** list who and what problem? _____

3. Have **you the patient** had any of the following, if you answer **YES** please explain:
   Major illness and/or injuries: **YES** or **NO** _____
   Surgery/Operations: **YES** or **NO** _____
   Hospitalization(s): **YES** or **NO** _____

4. Are **you the patient** currently taking medication (prescribed by a doctor, over-the-counter, vitamins or herbals): **YES** or **NO.** If **YES**, please list **ALL** medications below:
   _____
   _____
   _____
   _____

5. Are **you the patient** allergic to **ANY** medication(s), food(s), and/or latex products? **YES** or **NO**
   If **YES**, please list **what** you are allergic to and the **reaction** you had.
   _____
   _____

6. Are **you the patient** current on **ALL** immunizations/vaccinations? **YES** or **NO**
   If **NO**, what immunization(s)/vaccination(s) do you need? _____

7. Do **you the patient** use any type of tobacco product? **YES** or **NO**
   I use Cigarettes/Cigars/Pipe/Snuff, Chewing Tobacco, _____ per day for _____ years.

8. Do **you the patient** drink caffeine? **YES** or **NO** _____ cups/soft drinks/ tea/coffee/_____per day.

9. Do **you the patient** drink **ANY** alcohol? **YES** or **NO** _____ beer/wine/other _____ per day.

PLEASE TURN THE PAGE OVER AND COMPLETE THE SECOND PAGE OF THIS FORM. THANK YOU

MICHAEL H. FRITSCH, M.D., F.A.C.S., PROFESSOR

Patient Health History

Name of Patient:_____ **Date of Birth:**_____

10. Have **you the patient** had any problem related to the **(Circle or List):**

Eyes:	Yes	No
Glaucoma		
Cataract		
Macular Degeneration		
Retinopathy		
Blindness		
Ears:	Yes	No
Hearing Loss, Infections		
Cardiovascular:	Yes	No
Angina (Chest Pain)		
Arrhythmia		
Coronary Artery Disease		
High Blood Pressure		
Mitral Valve Prolapse		
Stroke		
Respiratory:	Yes	No
Sinus/Throat/Tonsils/Adenoid		
Lungs/Emphysema/COPS		
Pneumonia/Tuberculosis		
Hay Fever/Allergies		
Gastrointestinal:	Yes	No
Ulcer		
Cirrhosis/Hepatitis		
Gallstones		
Genitourinary:	Yes	No
Kidney/Bladder		
Prostate/Menopause		
Musculoskeletal:	Yes	No
Arthritis/Muscular Dystrophy		
Integumentary (skin):	Yes	No
Eczema/Psoriasis/Shingles		
Neurological:	Yes	No
Facial Paralysis – Bell's Palsy		
Epilepsy/Seizure		
Headache		
Head Injury/Skull Fracture		
Meningitis		
Multiple Sclerosis		
Neuropathy		
Psychiatric:	Yes	No
Anxiety/Depression		
Endocrine:	Yes	No
Diabetes/Pituitary/Thyroid		
Hematologic/Lymphatic:	Yes	No
Anemia/Hemophilia		
Immune:	Yes	No
HIV-AIDS/Lupus		
Rheumatoid Arthritis		
Cancer/Tumor:	Yes	No

Name of person completing this form:_____

Relationship to Patient: ____**Patient** ____**Parent** ____**Spouse** ____**Other:**_____

Signature:_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA); I have certain rights to privacy regarding my protected health information understand that this information can and will be used to:

- ✓ Conduct, plan and direct my treatment and follow-up among the multiple healthcare, providers who may be involved in my treatment directly and indirectly.
- ✓ Obtain payment from third party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review such Notice of Privacy Practices prior to signing this consent. I understand that Fritsch Otology has the right to change its Notice of Privacy Practices form time to time and that I may contact this organization at any time at the office address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Fritsch Otology restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Fritsch Otology is not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ I have read the Notice of Privacy Practices

_____ I decline to read the Notice of Privacy Practices

Date _____

Patient Name _____

Signature _____

Printed Name

If not patient _____

Address _____

Street City State Zip

The patient is unable to read the Notice of Privacy Practice or sign the acknowledgement/consent form as documented below:

Date: Initials: Reason:

CONSENT AND RELEASE OF PROTECTED INFORMATION

Permission to Release Records

We provide you with important diagnostic information about your hearing. It is important for your physician to have this information for your medical records. It is sometimes necessary to release diagnostic information in order to process insurance claims and insurance applications. By signing this form, you are giving us permission to send medical records to your physician and release diagnostic information to your insurance company. This release will be in effect until we receive a written notice from you stating we may no longer forward this information

_____ _____

Signature of patient or adult responsible party Date

Permission to Receive Records

In order to provide you with the best service, we may be required to contact your previous physicians, audiologist, hearing instrument specialist, or hearing aid manufacturer for information regarding your medical records and/or hearing instrument. This release will be in effect until we receive a written notice from you requesting we may no longer receive this information

_____ _____

Signature of patient or adult responsible party Date

Permission to Send Mail

I consent to Fritsch Otology's use or disclosure of my protected health information for purposes of delivering relevant product and/or technical marketing communication to me. I acknowledge that Fritsch Otology may receive financial support from the manufacturer in connection with such communications. By signing this request, I am giving permission for the above. This will be in effect until I submit a written notice to Fritsch Otology requesting that I may no longer be contacted.

_____ _____

Signature of patient of adult responsible party Date

Do we have your permission to do the following:

Leave a message on your answering machine at home?	YES	NO
Leave a message that we called at your place of employment?	YES	NO
Discuss your medical information with any member of your household?	YES	NO

_____ _____

Signature of patient or adult responsible party Date

_____

MEDICARE PATIENTS ONLY:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefit either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature of patient or adult responsibility party Date

If you have a supplemental policy and it is a MEDIGAP policy to which you Medicare Carrier automatically "crosses over," Fritsch Otology is required to keep a separate on file: I request MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information needed to determine these benefits payable for the related service.

_____ _____

Signature of patient or adult responsible party Date

MICHAEL H. FRITSCH, M.D.
FRITSCH OTOLOGY
9002 N MERIDIAN STREET SUITE 204
INDIANPOLIS, IN 46256

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: MARCH 1st, 2011

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.

OUR RESPONSIBILITIES:

Michael H. Fritsch, M.D. and Fritsch Otology take the privacy of your health information seriously. We are required by law to maintain that privacy and to provide you with this Notice of Privacy Practices. This Notice is provided to tell you about our duties and practices with respect to your information. We are required to abide by the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

The following categories describe different ways that we use and disclose your health information. For each category we explain what we mean and give some examples. Not every use or disclosure that is in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment:** We may use health information about you to provide you with treatment, health care or other related services. We may disclose your health information to doctors, nurses, audiologist, or other employees who are involved in taking care of you. Additionally, we may use or disclose your health information to manage or coordinate your treatment, health care or other related services. We may also disclose your medical information to other health care providers who are providing treatment to you, whether or not we are involved with your treatment at that time. **For example, we may disclose your hearing test on request of your PCP or we may give insurance information to Lab or Surgery Centers to schedule appointments.**

- **For Payment:** We may use and disclose your health information to bill and collect for the treatment and services we provide to you. We may send your health information to an insurance company or other third party for the payment purposes including to a collection service. We may also disclose your medical information to another health care provider or payor of health care for the payment activities of that entity. **For example, we disclose all information requested by insurance companies per their request for approval of payment on a claim. We also send information to a clearinghouse for billing statements to be mailed on our behalf.**

- **For Health Care Operations:** We may use and disclose your health information for health care operations. These uses and disclosures are necessary to run Michael H. Fritsch, M.D. and Fritsch Otology, to make sure you receive competent, quality health care, and to maintain and improve the quality of health care we provide. We may also provide your health information to various governmental or accreditation entities such as **the Joint Commission on Accreditation of Healthcare Organizations**, to maintain our license and accreditation. We may also disclose your medical information to another health care provider or payor for certain health care operations activities of

that entity, if that entity also has a relationship with you. **For example, we may disclose your medical information to a hospital for quality assessment and improvement activities of the organization.**

- **Incidental Uses and Disclosures:** We may occasionally inadvertently use or disclose your medical information when such use or disclosure is incident to another use or disclosure that is permitted or required by law. For example, while we have safe guards in place to protect against others overhearing our conversations that take place between the doctor, nurses, audiologist, or other Michael H. Fritsch, M.D. and Fritsch Otology personnel, there may be times that such conversations are in fact overheard. Please be assured, however, that we have appropriate safeguards in place to avoid such situations, and others, as much as possible.

- **Disclosures to You:** Upon a request by you, we may use or disclose your medical information in accordance with your request.

- **Limited Data Sets:** We may use or disclose certain parts of your medical information, called a "limited data set," for purposes of research, public health reasons, or for our health care operations. We would disclose a limited data set only to third parties that have provided us with satisfactory assurances that they will use or disclose your medical information only for limited purposes.

- **Disclosures to the Secretary of Health and Human Services:** We might be required by law to disclose your medical information to the Secretary of the Department of Health and Human Services, or his/her designee, in the case of a compliance review to determine whether we are complying with privacy laws.

- **De-Identified Information:** We may use your medical information, or disclose it to a third party whom we have hired, to create information that does not identify you in any way. Once we have de-identified your information, it can be used or disclosed in any way according to law.

- **Disclosures by Members of Our Workforce:** Members of our workforce, including employees, volunteers, trainees or independent contractors, may disclose your medical information to a health oversight agency, public health authority, health care accreditation organization or attorney hired by the workforce member, to report the workforce member's belief that we have engaged in unlawful conduct or that our care or services could endanger a patient, workers, or the public. In addition, if a workforce member is a crime victim, the member may disclose your medical information to a law enforcement official.

- **As Required By Law:** We will disclose your health information when required to do so by federal, state, or local law.

- **For Public Health Purposes:** We may disclose your health information for public health activities. While there may be others, public health activities generally include the following:

    - Preventing or controlling disease, injury, or disability;
    - Reporting births and deaths;
    - Reporting defective medical devices or problems with medications;
    - Notifying people of recalls of products they may be using; and
    - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **About Victims of Abuse:** We may disclose your health information to notify the appropriate government authority if we believe an individual had been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities:** We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws.

- **Judicial Purposes:** We may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute, but only if efforts have been made to tell you about the request, in which you were given an opportunity to object to the request, or to obtain an order protecting the information requested.

- **Law Enforcement:** We may release health information if asked to do so by a law enforcement official, if such disclosure is:

    - Required by law;
    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify to locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at the Covered Entity; or
    - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors:** In certain circumstances, we may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about the individuals to funeral directors as necessary to carry out their duties.

- **Organ and Tissue Donation:** We may disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Research:** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all individuals who received one medication to those who received another. All research projects, however, are subject to a special approval process. This process includes evaluating a proposed research project and its use of health information, trying to balance the research needs with your need for privacy of your health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. Additionally, when it is necessary for research purposes and so long as the health information does not leave Michael H. Fritsch, M.D. and/or Fritsch Otology, we may disclose your health information to researchers preparing to conduct a research project, for example, to help the researchers look for individuals with specific health needs. Lastly, if certain criteria are met, we may disclose your health information to researchers after your death when it is necessary for research purposes.

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose your health information when we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or lessen the threat or to law enforcement authorities in particular circumstances.

- **Military and Veterans:** If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- **National Security and Intelligence Activities:** We may release your health information to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others:** We may disclose your health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or for the conduct of special investigations.

- **Custodial Situations:** If you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain representations to us, we may disclose your health information to a correctional institution or law enforcement official.

- **Worker's Compensation:** We may disclose your health information as authorized by and to the extent necessary to comply with worker's compensation laws or laws relating to similar programs.

- **Suspected Abuse or Neglect:** If we believe that a person is a victim of child or adult abuse or neglect, we are required by law to report certain information to public authorities.

- **Communications Regarding Our Services or Products:** We may use and disclose your health information to make a communication to you to describe a health-related product or service of Michael H. Fritsch, M.D. and/or Fritsch Otology. In addition, we may use or disclose your health information to tell you about products or services related to your treatment, case management or care coordination, or alternative treatments, therapies, providers or settings of care for you. We may occasionally tell you about another company's products or services, but will use or disclose your health information to give you a promotional gift from us that is a minimal value.

- **Treatment Alternatives, Appointment Reminders and Health-Related Benefits:** We may use and disclose your health information to tell you about or recommend possible treatment alternatives or health-related benefits or services that may be of interest to you. Additionally, we may use and disclose your health information to provide appointment reminders. If you do not wish us to contact you about treatment alternatives, health-related benefits or appointment reminders, you must notify us in writing, and state which of those activities you wish to be excluded from.

- **Individuals Involved in Your Care or Payment for Your Care:** We may release health information about you to a family member, other relative, or any other person identified by you who is involved in your health care. We may also give information to someone who is involved with or helps pay for your care. We may also tell your family, friends, personal representative or other person responsible for your health care your condition and that you are at the Hospital.

- **Third Parties:** We may disclose your health information to certain third parties with whom we contract to perform services on our behalf. If we disclose your information to these entities, we will have an agreement by them to safeguard your information.

- **Disclosures of Records Containing Drug or Alcohol Abuse Information:** Because of federal law, we will not release your medical information if it contains information about drug or alcohol abuse without your written permission except in very limited situations.

OTHER USES OF HEALTH INFORMATION:

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made under the authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

You have the following rights regarding health information we maintain about.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Crystal Hazelwood, Office Manager at 9002 N Meridian Street, Suite 204, Indianapolis, IN 46260. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you or your responsible party about your health care in an alternative way or at a certain location.

  To request confidential communications, you must make your request in writing to Crystal Hazelwood, Office Manager at 9002 N Meridian Street, Suite 204, Indianapolis, IN 46260. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care.

  To inspect and copy health information that may be used to make decisions about you, you can submit your request in writing to Crystal Hazelwood, Office Manager at 9002 N Meridian Street, Suite 204, Indianapolis, IN 46260. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Amend:** You have the right to ask us to amend your health and/or billing information for as long as the information is kept by us.

  To request an amendment, your request must be made in writing and submitted to Crystal Hazelwood, Office Manager at 9002 N Meridian Street, Suite 204, Indianapolis, IN 46260. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for us;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures:** You have the right to request a list of certain disclosures that we have made of your health information.

  To request this list of disclosures, you must submit your request in writing to Crystal Hazelwood, Office Manager at 9002 N Meridian Street, Suite 204, Indianapolis, IN 46260. Your request must state a time period that may not be longer than six years and may not include dates before March 1st, 2011. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a twelve-month period will be free. For additional lists, during such twelve-month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **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 copy of this Notice at our website www.eardoc.us.

  To obtain a paper copy of this Notice, contact Crystal Hazelwood, Office Manager at 9002 N Meridian Street, Suite 204, Indianapolis, IN 46260.

WHO THIS NOTICE APPLIES TO:

This Notice applies to Michael H. Fritsch, M.D. and Fritsch Otology and those of:

- Any health care professional authorized to enter information into or consult your medical record.
- All employees of Michael H. Fritsch, M.D. and Fritsch Otology.
- Any student intern we allow to help you.

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice. We reserve the right to make revised Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in a clear and prominent location to which you have access. The Notice is also available to you upon request. The Notice will contain on the first page, the effective date. In addition, if we revise the Notice, you may request a copy of the current Notice in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with Michael H. Fritsch, M.D. and Fritsch Otology or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact June Bowden at (317) 848-9505 or 9002 N Meridian Street Suite 204, Indianapolis, IN 46260. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

If you have any questions about this Notice, please contact:

Crystal Hazelwood
Office Manager
9002 N Meridian Street Suite 204
Indianapolis, IN 46260
(317) 848-9505