



REGISTRATION FORM

Welcome to Whitman-Walker Clinic! We are so happy that you want us to provide care to you. We need you to fill out this form so that we can register you. Let us know if you have questions or if you need help. Several of the items below help us ensure that we are meeting the needs of the population we serve, so please be as thorough as you can be.

PLEASE PRINT CLEARLY.

DEMOGRAPHIC INFORMATION

Form section for demographic information including Today's Date, Date of Birth, Social Security Number, Legal Name (First, Middle, Last), Name you would like to be called, Sex, Sexual Orientation, Race, Ethnicity, and Language.

CONTACT INFORMATION

Form section for contact information including Your Address (Street, Unit #, Ward, City, State, Zip Code), Description of Housing, and Your E-mail Address.

Form section for phone and emergency contact information including Your Phone, Contact #1, Contact #2, and Emergency Contact Information (Name, Relationship, Address, Phone Number).

SERVICES AT WHITMAN-WALKER CLINIC

Form section for services at the clinic including Medical Care, Mental Health Counseling, Drug/Alcohol Treatment, Support Groups, and Legal Services.

PAYMENT FOR SERVICES

Please check what you have and present your insurance card to our staff so that we can scan it into our system. If you do not have insurance we accept or are uninsured, please skip to those sections.

UNINSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	If you do not have insurance, you must meet with our Public Benefits staff. You may be eligible for public insurance or a discount for your services. In order to determine your eligibility, you must provide income and residency documentation. If you do not bring them in, then you will be responsible for the full fee for your services.
INSURANCE WE ACCEPT	<input type="checkbox"/> Aetna—(Medical, Behavioral) <input type="checkbox"/> Anthem BlueCross/BlueShield—(Medical, Behavioral) <input type="checkbox"/> Carefirst BlueCross/BlueShield—(Medical, Behavioral) <input type="checkbox"/> Cigna—(Medical, Behavioral Health) <input type="checkbox"/> DC Alliance—Chartered—(Medical, Dental) <input type="checkbox"/> DC Alliance—Health Right—(Medical, Dental) <input type="checkbox"/> DC Alliance—Unison—(Medical) <input type="checkbox"/> DC Medicaid Fee for Service—(Medical, Behavioral Health, Dental) <input type="checkbox"/> DC Medicaid—Chartered—(Medical, Behavioral Health, Dental) <input type="checkbox"/> DC Medicaid—Health Right—(Medical, Behavioral Health, Dental) <input type="checkbox"/> DC Medicaid—Unison—(Medical, Behavioral Health) <input type="checkbox"/> Great West Health—(Medical) <input type="checkbox"/> MAMSI—(Medical, Behavioral Health) <input type="checkbox"/> Medicare Part B—(Medical, Behavioral Health) <input type="checkbox"/> OneNet (Alliance) PPO—(Medical, Behavioral Health) <input type="checkbox"/> Optimum Choice—(Medical, Behavioral Health) <input type="checkbox"/> Quality Plan Administrators—(Dental) <input type="checkbox"/> TRICARE - (Medical, Behavioral Health) <input type="checkbox"/> United Behavioral Health (Behavioral Health) <input type="checkbox"/> United Health Care—(Medical, Behavioral Health) <input type="checkbox"/> UHC Alliance—(Medical, Behavioral Health) <input type="checkbox"/> Value Options—(Behavioral Health) <input type="checkbox"/> VA Medicaid Fee for Service—(Medical, Behavioral Health) <input type="checkbox"/> VA Medicaid—Anthem Healthkeepers Plus—(Medical, Behavioral Health)
WWC DOES NOT accept:	MDIPA Anthem Blue Cross HMO Care First Blue Choice HMO Care First Blue Choice HMO Opt-Out Open Access Maryland Point of Service United Healthcare Primary Adult Care Program (PAC) United Healthcare Managed Care Organization <i>**We do not accept HMO insurance for any plans except the DC Medicaid and the DC Alliance programs.</i>
Responsible Party	In whose name is your insurance? <input type="checkbox"/> Self <input type="checkbox"/> Other: _____(Name & relationship) Is the responsible party a WWC Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance We Do Not Accept	If we do not take your insurance or you have an HMO, we encourage you to go back to your plan to select a provider who does take your insurance. Choosing to get your care with us will mean being charged for the full fee of your care.

INCOME INFORMATION

To comply with our federal grants, we collect general income information on all of our clients. Please check one of the following boxes that goes along with your gross income:

I am SINGLE	I am MARRIED
<input type="checkbox"/> \$ 0 – 902.50 monthly (0 – 10,830 annually)	<input type="checkbox"/> \$ 0 – 1,214.17 monthly (0 – 14,570 annually)
<input type="checkbox"/> \$ 902.51 – 1805.00 monthly (10,831 – 21,660 annually)	<input type="checkbox"/> \$ 1,214.18 – 2,428.33 monthly (14,571 – 29,140 annually)
<input type="checkbox"/> \$ 1805.01 – 2,707.50 monthly (21,661 – 32,490 annually)	<input type="checkbox"/> \$ 2,428.34 – 3,642.50 monthly (29,141 – 43,710 annually)
<input type="checkbox"/> \$ 2,707.51 or more, monthly (32,491, or more annually)	<input type="checkbox"/> \$ 3,642.50 or more, monthly (43,710 or more annually)

Acknowledgement of Responsibility for Payment for Services and Assignment of Benefits

- You are responsible for all charges and fees for your care, except any that might be covered by insurance that we accept.
- Payment, including co-insurance, co-pays, and self pay / sliding fee payments are due at the time of service.
- For uninsured or underinsured clients, if your income or residency changes, please bring in documentation of those changes to the Public Benefits Unit for re-assessment on the sliding fee scale and/or Grant Supported care.



CONSENTS AND ACKNOWLEDGEMENTS

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we provided you with some information and key documents. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a staff person. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I voluntarily agree to receive services from WWC, and authorize the providers of WWC to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications *at any time*, to the extent the law allows. I know that the care I will receive may include tests, injections and other medications, etc, which are of minimal risk and based on established medical criteria. Finally, I know that WWC sometimes has Students/Residents being trained as doctors, nurses, therapists and other health care providers who might be helping to care for me. These students will be supervised at all times.

I understand that WWC is committed to involving me in my care and that no one can be given care at WWC without agreeing to the care unless there is an emergency. If there is an emergency, I know that someone at WWC may help me without waiting for me to say okay. I understand that some services require me to sign an Informed Consent to Treat so I may be asked to complete that later.

Patient Initials _____

NOTICE OF PRIVACY PRACTICE

I have been given a copy of WWC's Notice of Privacy Practices and I understand that it is there to protect my personal health information. I have had the chance to ask questions about it and feel comfortable with the protections that it offers me. I understand that there are times when my personal health information may be shared, as the law allows, such as: if I am a danger to myself or others, if there is suspected child or elder abuse, and the mandatory reporting of certain diseases.

WWC is a participant in the DC Regional Health Information Organization (DC RHIO). The DC RHIO stores patient medical information that is exchanged through a network of participating hospitals and clinics. DC RHIO participants may use and disclose medical information about you with other participants for treatment, payment and health care operations, consistent with HIPAA requirements and the DC RHIO policies, including medical information collected by WWC. If you have questions regarding our participation in the DC RHIO, please contact the Director of Compliance at 202-797-3572 or compliance@wwc.org.

Patient Initials _____

INTEGRATED MODEL OF CARE

WWC offers a wide variety of services to its clients. I understand that in order for me to get the best care possible, programs within WWC may share information concerning my health to ensure the quality and continuity of my care across service areas.

Patient Initials _____

PATIENT RIGHTS AND RESPONSIBILITIES AND CLIENT HANDBOOK

I have been given a copy of the WWC Patient Rights and Responsibilities and understand that both the Rights and the Responsibilities laid out in that document must govern my interactions at Whitman-Walker Clinic. I also understand that both I and WWC, will be held accountable if those Rights and Responsibilities are violated. The process by which I may file a complaint against WWC is a Grievance. I understand that I have a right to file a Grievance and information about the Grievance process is in the Client Handbook. The Client Handbook contains information about being a client at the Clinic, including services that we offer, hours of operation, and contact information for services. I have been provided a copy of the Client Handbook.

Patient Initials _____

RELEASE OF INFORMATION FOR BILLING AND CONSENT TO REIMBURSE

I know that WWC needs to send parts of my personal health information to organizations that help pay for my care, such as my insurance company or an organization that grants money to WWC. I allow WWC to release the relevant parts from my records so that my care can be paid for. If I do not feel comfortable with this, then I understand that WWC will have to charge me for my services and that I will receive a bill. For public benefits and Sliding Fee Scale benefit I need to bring in certain documents. If I do not bring them in, then I know that I am responsible for the full fee for my services. I know that I am responsible for all charges not covered by my insurance, including all self-pay charges and my portion of any sliding fee scale charges.

Patient Initials _____

<u>Signature:</u>	<u>SSN:</u>
<u>Print Name (Print relationship also, if other than patient):</u>	<u>Date:</u>



The Health Insurance Portability and Accountability Act

NOTICE OF PRIVACY PRACTICES

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

A federal law called the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) creates new rights for clients of health care organizations. One of those rights is to information regarding the provider’s privacy practice. **Under federal regulations, we must provide you with a copy of this Notice of Privacy Practices and ask that you sign a document stating that we gave the notice to you.** You may review the Notice of Privacy Practices immediately or at a later time. At some point, you should read it carefully because it explains:

- Generally how we use health care information about you;
- That we, like other health care providers, may use and disclose health information about you as part of your treatment, to arrange for payment for services provided, and for our internal operations. We are not required to have separate permission for these uses and disclosures;
- Other circumstances where we may use or disclose information about your health where we are not required to get your permission first;
- The rights you have with respect to health information we have about you, namely:
 - Your right to have a copy of this privacy notice;
 - Your right to review and copy health information that we may have about you;
 - Your right to an accounting for how we use and disclose your health information, other than for treatment, payment or health care operations;
 - Your right to request restrictions on how we use your health care information;
 - Your right to request an amendment to information in our records that you think is in error; and your right to file a complaint if you think your privacy rights have been violated.

At Whitman-Walker, we take your confidentiality very seriously. We encourage you to read this notice and keep a copy of this notice for your records.

THE POLICIES IN THIS NOTICE BECOME EFFECTIVE ON APRIL 14, 2003.

Our Pledge Regarding Your Health Information

This Notice of Privacy Practices (the “Notice”) describes the privacy practices of Whitman-Walker Clinic, which includes its employees, volunteers, interns and contractors.

Whitman-Walker Clinic wants you to know that nothing is more central to our operations than maintaining the privacy of your health information (“Protected Health Information” or “PHI”). PHI is information about you, including basic demographic information that may identify you and that relates to your past, present or future health or condition and dispensing of pharmaceutical products to you. We take this responsibility very seriously.

We are required by federal and applicable D.C., Maryland and Virginia law to protect the privacy of your health information and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. This Notice describes how we may use and disclose PHI about you to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by federal and state laws. The Notice also describes your rights with respect to your PHI.

Whitman-Walker Clinic is required to follow the terms of the Notice currently in effect whenever we use or disclose your PHI. We will not use or disclose PHI about you without your written authorization, except as described in this Notice.

Certain programs within Whitman-Walker Clinic are not governed by this Notice. These include our legal services program, our HIV testing and counseling program, and many of our peer support group and other group programs. These programs are not treated as covered entities providing health care services for the purposes of federal privacy regulations. In general, our health care operations can share information about you with these programs only if you provide a signed authorization form. These programs are also governed by other standards that protect your privacy, including state laws and professional ethics restrictions.

We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon your request to our Privacy Office listed below, we will provide a revised Notice to you. We will also post the revised Notice on our website at www.wwc.org within 30 days of any revisions we make.

Please note that WWC is a participant in the DC regional Health Information Organization (“DC RHIO”). The DC RHIO stores patient medical information that is exchanged through a network of participating hospitals and clinics. DC RHIO participants may use and disclose medical information about you with other participants for treatment, payment and health care operations, consistent with HIPAA requirements and the DC RHIO policies, including medical information collected by WWC. If you have specific questions about WWC’s participation in the DC RHIO, please contact WWC’s Senior Privacy Officer, at 202-797-3572 or compliance@wwc.org.

How We May Use and Disclose Your PHI Without Your Permission

FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS:

As permitted under federal and applicable state law, we will use or disclose your PHI without your express authorization for three purposes: (i) treatment, (ii) payment and (iii) health care operations. For each of these categories, we provide an example of what we mean below.

For treatment. We may use or disclose your PHI to provide you with medical or behavioral health services. The following list provides examples of how we may use or disclose your PHI for treatment:

- **Direct Treatment.** Our physicians or social workers may look at your medical records in order to plan your future treatment.
- **Reminders.** We may contact you by telephone or mail to provide reminders regarding your appointments.
- **Treatment Alternatives.** We may contact you by mail or telephone to provide you with information about other treatment alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may contact you by mail or telephone to provide you with information about health-related benefits or services that may be of interest to you.

For payment. We may use or disclose your PHI so that the medical services you receive may be billed to and payment collected from you, your health insurer or another party that arranges or pays the cost of some or all of your health care. For example:

- We may contact Medicare, Medicaid, or your insurance carrier to determine whether it will pay for your treatment and the amount of your copayment responsibility.
- We may submit information about the services you received to Medicare, Medicaid or a third-party payor in order to get paid for the services we provide.
- We receive a great deal of our funding from federal, state and local grants. As a condition of receiving those grants, funders regularly review information about the services we provide to clients.

For health care operations. We may use or disclose your PHI for operations that are necessary to operate Whitman-Walker Clinic and ensure that you receive quality health services. For example:

- We may use information in your health record to monitor the quality and effectiveness of the service we provide.
- Organizations accrediting our services may ask to see sample medical records to determine if our practices meet acceptable standards.

FOR OTHER SPECIAL CIRCUMSTANCES:

There are other special circumstances when we are permitted under federal and applicable state law to use or disclose your PHI without your permission. The following explains when these circumstances may arise in two categories: (i) when we are likely to use or disclose your PHI and (ii) when we are permitted under law, but probably will not use or disclose your PHI.

We are likely to use or disclose your PHI for the following purposes:

Business associates: There are some services provided by us through contracts with other companies, who are our “business associates.” Federal law requires us to enter into a contract with these business associates to ensure that they will appropriately safeguard your PHI. For instance, we may contract to have certain of our services delivered by another health care provider or we may use a billing service for submitting our claims. When these services are contracted for, we may disclose PHI about you to our business associates so that they can perform the job we have asked them to do or bill an insurance company or managed care group for services rendered. But these business associates will be required to protect any PHI they receive in accordance with federal and applicable state laws, regulations and policies.

Individuals Involved in Your Care or Payment for Care. We may release PHI about you that is relevant for a friend, personal representative, spouse, domestic partner or family member who is involved in your medical care. If you are present, we can make these disclosures when you do not object or we can reasonably infer that you agree. If you are not present or are incapacitated, we may disclose certain PHI about you if we determine that the disclosure would be in your best interest.

Disclosures to parents or legal guardians: If you are a minor, we may release PHI about you to your parent or legal guardian when we are permitted to or required to under federal and applicable state law.

Workers’ compensation: We may disclose PHI about you to the extent authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs established by law.

Public health: As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability. These activities may include the following:

- Mandatory disclosures to report child abuse or neglect;
- Disclosures to report reactions to medications or other products to the U.S. Food and Drug Administration or other authorized entity;
- Disclosures to notify individuals of recalls on products they may be using; and
- Disclosures (if required by law) to individuals who may have been exposed to disease or may be at risk for contracting or spreading a disease.

Law enforcement: We may disclose PHI about you for law enforcement purposes as required by law or in response to a request by a law enforcement official. These disclosures of your PHI may be:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or 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 crimes conducted on our premises or against a member of our workforce; and

- In an emergency circumstance, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

As required by law: We must disclose PHI about you when required to do so by federal, state or local laws.

Health oversight activities: We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for the government to monitor the health care system, government programs, and compliance with federal and state laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

United States Department of Health and Human Services: Under federal law, we are required to disclose your PHI without your permission, if this PHI is requested by the U.S. Department of Health and Human Services to determine if we are in compliance with the federal laws and regulations regarding protecting the confidentiality of health information.

Research: Under certain circumstances, we may use or disclose your PHI for research purposes. Before we use or disclose your PHI, however, the research project will have to be approved through a special approval process by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also use or disclose your PHI for research purposes if we obtain your express written authorization for this use or disclosure.

Fundraising: Currently, Whitman-Walker Clinic does not use client lists for fundraising purposes. However, we may elect to do so in the future. If we do so, the sole information we will use as part of this process is your name, address, and telephone number. You may receive fundraising contacts even if we do not use client lists for fundraising purposes. For instance, if you are a past donor or on a list of potential likely donors that we acquire from third parties, you may receive fundraising solicitations from us. The fact that you have received a solicitation does not mean that we have used information gained in our health care operations. However, our Development Office will gladly remove you from our solicitation lists. If you do not want receive solicitations, you can either call the Development Office at 202-797-3520 or write to the Development Office, Whitman-Walker Clinic, 1701 14th St. NW, Washington, DC 20009.

Victims of abuse, neglect, or domestic violence: We may disclose PHI about you to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose your PHI for this purpose to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else or the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you. When we make this disclosure, we will notify you.

Administrator or Executor: Upon your death, we may disclose your PHI to an administrator, executor or other individual so authorized under applicable state law.

Although we may not engage in these activities, we may use or disclose PHI about you for the following purposes under federal or state law without your permission:

Coroners, medical examiners, and funeral directors: We may release PHI about you 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 disclose PHI to funeral directors consistent with applicable law to carry out their duties.

Organ or tissue procurement organizations: Consistent with applicable law, we may disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Notification: We may use or disclose PHI about you to an entity assisting in a disaster relief effort so that your family, personal representative or friends may be notified about your condition, status and location.

Correctional institution: If you are or become an inmate of a correctional institution, we may disclose to the institution or its agents PHI necessary for your health and the health and safety of others.

To avert a serious threat to health or safety: We may use and disclose PHI about you when 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 the threat.

Military and veterans: If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.

National security and intelligence activities: We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective services for the President and others: We may disclose PHI about you to authorized federal official so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

How We May Use or Disclose Your PHI For Other Purposes

We will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above (or as otherwise permitted or required by law).

You may revoke this authorization in writing at any time. If you decide to revoke your authorization, you must submit a request to revoke in writing to our Privacy Office at the address listed below. Your revocation will become effective upon its receipt by us. Your revocation will not have any effect on any action taken by us in reliance upon the authorization before we received written notice of the revocation.

Our Legal Services Program: Whitman-Walker Clinic operates a legal services program. However, if you receive services from our legal services department, we do not automatically share information about clients who may receive services from our other organizational components. If our legal services staff or volunteers need health information about you for your legal representation, they will ask you to sign an authorization form.

Your Rights Regarding Your PHI

You have the following rights with respect to PHI about you:

- *Obtain a paper copy of the Notice upon request.* You may request a copy of this Notice at any time. To obtain a copy, go to www.wwc.org or contact the Whitman-Walker Clinic Privacy Office at the address or number set forth below.
- *Inspect and obtain a copy of PHI.* You have the right to access and copy PHI about you contained in a “designated record set” for as long as we maintain the PHI. The “designated record set” usually will include prescription and billing records. To inspect or copy PHI about you, you must send a written request to the **Whitman-Walker Clinic Privacy Office at 1701 14th Street NW, Washington, DC 20009**. We will respond to your request in writing within 30 days (or 60 days if the PHI is located off-site). We may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. We may deny your request if: (i) we have reasonably determined that providing access to PHI would endanger your life or safety or cause substantial harm to you or another person, (ii) the PHI references another person and we do not have the required permission to disclose; or (iii) some other legal requirement prohibits us from disclosing this information to you. If we deny your request, we will notify you in writing and provide you with the opportunity to request a review of the denial.
- *Request an amendment of PHI.* If you feel that PHI about you contained in a designated record set maintained by us is incomplete or incorrect, you may request that we amend it. The designated record set usually will include prescription and billing records. You may request an amendment for as long as we maintain the PHI in a designated record set. To request an amendment, you must send a written request to **Whitman-Walker Clinic Privacy Office at 1701 14th Street NW, Washington, DC 20009**. Your request must identify: (i) which information you seek to amend, (ii) what corrections you would like to have made and (iii) why the information needs to be amended. We will respond to your request in writing

within 60 days (with a possible 30-day extension). In our response we will either: (i) agree to make the amendment or (ii) inform you of our refusal to make the amendment, explain our reason and outline any procedure that is available for you to appeal. We may deny your request to amend for certain reasons. If we deny your request for amendment, you also have the right to file a statement of disagreement with the decision and we will provide you with a rebuttal to your statement, both of which will be attached to your designated record set.

- *Receive an accounting of disclosures of PHI.* You have the right to request an accounting of the disclosures we have made of PHI about you after April 14, 2003 for most purposes other than treatment, payment, or health care operations. The accounting will exclude disclosures we have made directly to you, disclosures made with your authorization, incidental uses and disclosures, disclosures to friends or family members involved in your care, disclosures for notification purposes and certain other exceptions. To request an accounting, you must submit your request in writing to **Whitman-Walker Clinic Privacy Office at 1701 14th Street, NW, Washington, DC 20009**. Your request must specify the time period, but may not be longer than six years. We will respond to your request in writing within 60 days of receiving your request (with a possible 30-day extension). The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for the cost of any subsequent accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.
- *Request communications of PHI by alternative means or at alternative locations.* You have the right to request that we communicate with you in a certain way or at a certain location. For example, you may request that we contact you about medical matters only in writing at a specific address. To request confidential communication of PHI about you, you must submit your request in writing to **Whitman-Walker Clinic Privacy Office at 1701 14th Street, NW, Washington, DC 20009**. Your request must state how, where or when you would like to be contacted. We will accommodate all reasonable requests.
- *Request a restriction on certain uses and disclosures of PHI.* You have the right to request a restriction or limitation on our use or disclosure of PHI about you by sending a written request to the **Whitman-Walker Clinic Privacy Office at 1701 14th Street, NW, Washington, DC 20009**. You must identify in this request: (i) what particular information you would like to limit, (ii) whether you want to limit use, disclosure or both and (iii) to whom you want the limits to apply. Although we will consider your request carefully, we are not required to agree to those restrictions. We will provide you with a written response to your request within 30 days. If we do agree to restrict use or disclosure of your PHI, we will not apply these restrictions in the event of an emergency. We also have the right to terminate the restriction if: (i) you agree orally or in writing or (ii) we inform you of the termination, which becomes effective only with respect to your PHI created or received after we inform you of the termination.

For More Information or to Report a Problem

If you have questions or would like additional information about Whitman-Walker Clinic's privacy practices, you may contact the Privacy Officer at **Whitman-Walker Clinic Privacy Office at 1701 14th Street NW, Washington, DC 20009**. **Call us at 202-797-3572. Our fax number is 202-797-3504.**

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Office or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, contact our Privacy Office at the address and number listed above. All complaints must be submitted in writing. You will not be penalized in any way for filing a compliant.

Effective Date

This Notice is effective as of April 14, 2003.

Acknowledgement of Receipt of Notice of Privacy Practices from Whitman-Walker Clinic is indicated by your signature on our Consents form within your record.