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Medical History Form

Beijing Acupuncture & Chinese Herbal Medicine
6255 University Ave., Suite 202, Middleton, WI 53562

Phone: (608) 238-3333. Fax: (608) 238-3333 www.beijing-acupuncture.com

Today's date ____/____/____

Patient Name _____ Male / Female Age ____ Date of Birth ____/____/____

Height ____ Weight ____ Marital Status _____ Occupation _____

Phone (H) (____)____-____ (W) (____)____-____ Employer _____

Address _____ City _____ State ____ Zip _____

Spouse's Name _____ DOB ____/____/____ Phone (H) (____)____-____ (W) (____)____-____

Family Physician _____ Phone (____)____-____ Referred by _____

Emergency contact information: The name of the person you would like to contact in emergency _____

Phone (H) (____)____-____ Phone (W) (____)____-____ Relationship _____

Insurance _____

2nd Insurance _____

Subscriber's Name _____

Subscriber's Name _____

Date of Birth ____/____/____

Date of Birth ____/____/____

I.D# _____

I.D# _____

Please list things you are allergic to:

Medicine _____

Food _____

Herbs _____

Others _____

Please list medications you are currently taking

Do you have or are you any of the following?

Pacemaker Electric Implants Metal Implants Severe Bleeding Disorders

Pregnant HIV Positive Hepatitis A/B/C

Your main complains today: (indicate the pain level 0-10, if you have pain)

Please check if you have had any of the following conditions:

General

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Strong Thirst (hot or cold drinks) | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sudden Energy Drop | <input type="checkbox"/> Tetanus Shot |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Poor Sleep Habits | <input type="checkbox"/> Frequent cold/flu |

Skin and Hair

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Open sore | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Acne | <input type="checkbox"/> Loss of Hair |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Corns | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Warts | <input type="checkbox"/> Nail Problems |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Eczema | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Headaches | | |

Cardiovascular

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Myocarditis | <input type="checkbox"/> Coronary Heart Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Pneumatic Heart Disease | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hardening of Arteries |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Mitral Stenosis | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Mitral Prolapse | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet |

Respiratory

- | | | |
|--|---|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain w/ deep breath |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Production of Phlegm |
| <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Emphysema | | |

Gastrointestinal

- Nausea
- Vomiting
- Bad Breath
- Abdominal Pain or Cramps
- Indigestion
- Ulcer

- Constipation
- Gas
- Blood in Stools
- Rectal Pain
- Chronic Laxative Use
- Colitis

- Diarrhea
- Belching
- Black Stools
- Hemorrhoids
- Acid Reflux

Genitourinary

- Bed Wetting
- Kidney Infections / Stones
- Genital Herpes
- Cystitis

- Blood in Urine
- Painful Urination
- Venereal Disease
- Incontinence

- Frequent Urination
- Bladder Infections
- Prostate Problems

Pregnancy and Gynecology

- Number of Pregnancies
- Number of Abortions
- Number of Births
- Number of Miscarriages
- Use of Birth Control
- Clots
- Hot Flash/Night Sweats
- Osteoporosis

- Age at 1st Menstruation
- _____ Time between Menstruation
- _____ Duration of Menstruation
- _____ First Date of Last Menstruation
- Irregular Periods
- Endometriosis
- Frequent changes in emotion

- Unusual Character (heavy/light)
- Vaginal Sores
- Vaginal Discharge
- Breast Lumps
- Painful Periods/Cramps
- Uterine Fibroids

Musculoskeletal

- Neck Pain
- Back Pain
- Hand/Wrist Pain

- Muscle Pains
- Muscle Weakness
- Shoulder Pain

- Knee Pain
- Foot/Ankle Pain
- Hip Pain

Neuropsychological

- Seizures
- Areas of Numbness
- Concussion
- Bad Temper
- Difficulty Concentrating

- Dizziness
- Lack of Coordination
- Depression
- Easily susceptible to stress

- Loss of Balance
- Poor Memory
- Anxiety
- ADD

Infection

- Measles
- Rheumatic Fever
- Malaria
- Small Pox

- Mumps
- Tuberculosis
- Chicken Pox

- Whooping Cough
- Typhoid Fever
- Scarlet Fever

Additional information related above listed (you checked)

List of Hospitalizations & Surgeries

Other information

	No	Yes	How many yrs	Daily consumption	Your comments
Coffee	___	___	_____	_____	_____
Tea	___	___	_____	_____	_____
Alcohol	___	___	_____	_____	_____
Tobacco	___	___	_____	_____	_____
Vitamins	___	___	_____	_____	_____

Family History (please include the relative's age)

- | | |
|--|--|
| <input type="checkbox"/> Migraines _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Gall Stones _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Epilepsy _____ |

The following is for car accident related injury only

Date of accident ___/___/_____ Accident occurred at City _____, State _____

Patient's Car Insurance _____ Phone _____

Claim # _____ Adjuster _____ Phone _____

Address _____ City _____ Zip _____

Fault's car insurance _____ Phone _____

Claim # _____ Adjuster _____ Phone _____

Address _____ City _____ Zip _____

Fault person's name _____

Patient's attorney _____ Phone _____

Address _____ City _____ Zip _____

Contact person _____ Fax _____

CHINESE MEDICINE / ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I have been informed of the risk and benefits of the procedures and products listed below that apply to my treatment:

“Chinese medicine” means a distinct system of health care that diagnoses and treats illness, injury, pain, or other conditions by regulating the flow and balance of energy to restore and maintain health. It is different from the conventional western medicine.

“Acupuncture” means primarily the insertion of sterile needles through the skin at certain points on the body, with or without the application of electric current and/or heat, for the purpose of promoting health and balance as defined by the principles of Chinese medicine. Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points and use of mechanical, magnetic, heating, electrical, or laser stimulation of acupuncture points, particularly in instances where such stimulation is applied across the midline of the trunk or in patients with a history of heart trouble.

“Chinese herbal medicine” means using a complex combination of herbs to create one remedy. Chinese medical doctors works to match the therapeutic characteristics and nature of herbs to formulate a prescription that will meet the patient’s individual needs.

“Moxibustion” means the thermal stimulation of acupuncture points or specific body areas by utilizing the burning of the dried form of the herb, Artemisia Vulgaris; the heat may be applied on or above specific points or areas or on the acupuncture needle itself.

“Cupping” means a therapeutic method of oriental medicine that utilizes a partial vacuum created in a glass dome or cup that is then applied to a particular area of the body.

“GuaShao” means scraping an area of skin with a smooth instrument.

“Acupressure / TuiNa / Chinese Medical message” means applying pressure to specific acupoints to release tension and increase circulation. Tuina is a method of Chinese Bodywork that utilizes soft tissue manipulation, acupoints, and structural realignment methods to treat a wide variety of musculoskeletal and internal organ disorders. Tuina utilizes Traditional Chinese Medical theory in assessing energetic and functional disorders. In addition, the use of external herbal medicines and therapeutic exercise is also included.

The benefits and risks of receiving treatments described above have been explained to me. Although rare, certain side effects may result from acupuncture and Chinese Medicinal treatment, I understand that each procedure or treatment has specific risk and benefits.
Minor bruising; Minor burning or blistering; Some pain at the site of the treatment.
Needle sickness; Broken Needles; Infection and the risks from needling in the vicinity of an infection.
Herbal allergies; Herbal sickness.

I understand that I am responsible for my bill
I authorize payment directly to my clinician
I authorize the use of this form and other medical forms for all of my insurance submissions
I have read the NOTICE OF PRIVACY PRACTICES and authorize Beijing Acupuncture and Chinese Medicine Clinic to use or disclose my health information in the manner described in the NOTICE OF PRIVACY PRACTICES.
I permit a copy of this authorization to be used in place of the original
I direct my previous health care providers to release medical record to this clinic
I authorized my clinician to act as my agent to obtain payment from my insurance companies

Doctor (signature) _____ Date _____

Patient’s signature _____ Date _____

Consent to treat a minor child or disability: I authorized _____ and whomever he/she designates as assistants to administer acupuncture care as deemed necessary to my _____ (relationship)

Patients name _____ Adults or Guardian’s signature _____ Date _____

Consent to be treated by an intern: I authorized intern _____ to administer acupuncture care to me. Patient’s signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices when you call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, Beijing Acupuncture and Chinese Herbal Medicine Clinic will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by our employees and others that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to seek payment of your health care bills and to support the operation of Beijing Acupuncture and Chinese Herbal Medicine Clinic. Following are examples of the types of uses and disclosures of your protected health care information that Beijing Acupuncture and Chinese Herbal Medicine Clinic are permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by Beijing Acupuncture and Chinese Herbal Medicine Clinic once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other Physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of The Doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment to our Doctors

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of Beijing Acupuncture and Chinese Herbal Medicine Clinic. These activities include, but are not limited to, quality assessment activities, employee review activities, training of our students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to our students that see patients in our clinic; we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your student clinician; we may also call you by name in the waiting room when your clinician is ready to see you; we may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment; we will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that Beijing Acupuncture and Chinese Herbal Medicine Clinic has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Beijing Acupuncture and Chinese Herbal Medicine Clinic Doctors may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, The Doctor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we have attempted to obtain your consent but are unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and the Doctor determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on Beijing Acupuncture and Chinese Herbal Medicine Clinic premises, and (6) medical emergency and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and Beijing Acupuncture and Chinese Herbal Medicine Clinic created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.Seg

2. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that Beijing Acupuncture and Chinese Herbal Medicine Clinic use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Beijing Acupuncture and Chinese Herbal Medicine Clinic are not required to agree to a restriction that you may request. If our Doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If our Doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have the Doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to

your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice by reading it where it is posted or by receiving it electronically.

3. Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights by us. You may file a complaint with us by notifying us. We will not retaliate against you for filing a complaint.