REGISTRATION

NAME | BIRTH DATE | DATE

REFERRED BY | SGLE MAR WID DIV CHILD

PRESENT ADDRESS | PHONE

CELL PHONE | E-MAIL | SS #/SIN

PREVIOUS ADDRESS | (DATES) FROM TO

OCCUPATION | EMPLOYER

EMPLOYER'S ADDRESS | PHONE

NAME OF SPOUSE OR PARENT/GUARDIAN | PHONE | CELL PHONE

ADDRESS | E-MAIL

OCCUPATION | EMPLOYER

EMPLOYER'S ADDRESS | PHONE

CREDIT REFERENCE OR RESPONSIBLE PARTY | PHONE

ADDRESS

MEDICAL INSURANCE - COMPANY | POLICY NO

ADDRESS

HOSPITAL INSURANCE - COMPANY | POLICY NO

ADDRESS

OTHER HEALTH INSURANCE

REMARKS

LAWRENCE S. REED, M.D., F.A.C.S.

(212) 772-8300

45 East 85th Street , New York, NY 10028

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient:				
DOB	Age	Marital Status	Weight	lbs
What surgery/procedure are you considering?			Height	ft in

1. Are you a smoker? ☐ Yes ☐ No If so, please tell us how much and for how long. If you recently quit , please tell us how long ago:_____
2. Are you a regular coffee, tea or caffeinated soda drinker?
   ☐ Yes ☐ No
3. Do you consume alcohol on a regular or social basis?
   ☐ Yes ☐ No
4. Do you exercise regularly?
   ☐ Yes ☐ No

PHYSICIANS REGULARLY SEEN: If you are presently under the care of any type of doctor – whether an internist, primary care or specialist – for a current, chronic or long term medical condition - please list the doctor(s) names, phone numbers and specialty. If you do not have an internist or primary care physician, please indicate that.

Please note: We will not contact any of your physicians without your express permission

_____

_____

_____

_____

ALLERGIES AND SENSITIVITIES:			EXPLANATION
Penicillin or other antibiotics	Yes	No	
Morphine, codeine, demerol or other narcotics	Yes	No	
Sedative or anxiety medication – Valium, Xanax, Ativan etc	Yes	No	
Any of the classes of depression medication including Zoloft, Prozac or MAO Inhibitors	Yes	No	
Anti-nausea or anti-seizure medication or neuroleptics	Yes	No	
Novocain or other local anesthetics	Yes	No	
Sodium Pentothal or other anesthetics	Yes	No	
Sulfa drugs	Yes	No	
Tetanus antitoxin or other serums	Yes	No	
Adhesive tape	Yes	No	
Iodine or Methiolate, Phisohex or other antiseptics	Yes	No	
Any other drug or medication	Yes	No	
Any foods such as eggs, milk or chocolate	Yes	No	
Do you have a latex allergy	Yes	No	
Do you have a surgical tape allergy	Yes	No	
Any reactions to puffers or inhalers	Yes	No	

DRUGS RECENTLY TAKEN: Please inform us of any of the following drugs you have taken within the past six months (unless another time frame is specified)

Cortisone/steroids (taken within the past 2 years)	Yes No
Antidepressants (including MAO inhibitors)	Yes No
Anticoagulants (blood thinners)	Yes No
Tranquilizers	Yes No
Hypertensives (high blood pressure medication)	Yes No
Cardiac drugs (Pronestyl, digitalis, etc)	Yes No
Inderal	Yes No
Accutane (within the past year)	Yes No
Diuretics (water pills)	Yes No
Anti – diabetic drugs	Yes No
Any other prescribed or non-prescribed medications	Yes No NONE
Please list	
Any homeopathic, herbal or vitamin preparations	Yes No NONE
Please list	

In the following space, please provide a complete list of all drugs/preparations/medications which you CURRENTLY take, including those listed above. This list is helpful in avoiding possible cross-drug reactions.:

DETAILED MEDICAL HISTORY - DO YOU OR A MEMBER OF YOUR FAMILY HAVE A HISTORY OF:

		WHO/WHAT
Diabetes (High Blood Sugar)	Yes No	
High Blood Pressure	Yes No	
Low Blood Sugar	Yes No	
Mitral valve prolapse	Yes No	
Pacemaker	Yes No	
Rheumatic heart disease	Yes No	
Coronary Surgery	Yes No	
Angina	Yes No	
Atrial Fibrillation	Yes No	
Heart Disease - other	Yes No	
Lung Disease	Yes No	
Kidney Disease	Yes No	
Pulmonary embolus	Yes No	
Neurological disorders	Yes No	
Thyroid, pancreatic or other endocrine disorders such as hypoglycemia (low blood sugar)	Yes No	
Phlebitis	Yes No	
Migraine headaches	Yes No	
Abnormal bleeding	Yes No	
Anormal clotting	Yes No	
Anesthetic problems		

DETAILED MEDICAL HISTORY (cont)			WHO?WHAT
Cancer (including skin)	Yes	No	
Tuberculosis	Yes	No	
Anemia	Yes	No	
Hepatitis	Yes	No	
Prostate disorders	Yes	No	
Acid regurgitation (heartburn)	Yes	No	
Rheumatic fever	Yes	No	
Emphysema	Yes	No	
Any weight change past 12 months	Yes	No	
Stomach problems	Yes	No	
Ulcers	Yes	No	
Urination problems	Yes	No	
Do you wear contact lenses	Yes	No	
Do you wear glasses	Yes	No	
Do you wear dentures	Yes	No	
Do you use a hearing aid	Yes	No	
Do you form keloids	Yes	No	
Do you form thick red raised scars on your body	Yes	No	
Have you ever undergone scar revisions or treatment for improving scarring	Yes	No	
Other serious illness or medical problems	Yes	No	
FEMALE PATIENTS	Yes	No	
Number of pregnancies Number of children			
Do/Did you breast feed	Yes	No	
Last menstrual period	Yes	No	
Have you suffered any miscarriages	Yes	No	

When was your last dental, oral surgery or dental cleaning?

BLEEDING PROFILE			EXPLANATION
Do you have any problems with bleeding in general?	Yes	No	
After a razor cut?	Yes	No	
After a tooth extraction	Yes	No	
After a previous surgery?	Yes	No	
After a delivery?	Yes	No	
Do you bruise easily or remain bruised for long periods of time?	Yes	No	
Have you ever received blood transfusions or blood products (plasma, platelets, etc)? **PLEASE GIVE DETAILS**	Yes	No	
Is there a family history of bleeding problems?	Yes	No	
Do you use aspirin regularly?	Yes	No	
NSAIDS such as Advil, Motrin, Ibuprofen, Aleve, Naproxen etc?	Yes	No	
Do you take vitamin E	Yes	No	
Do you take blood thinners?	Yes	No	

FREQUENCY

Do you take any of the following drugs which contain aspirin	Yes	No
Darvon	Yes	No
Percodan	Yes	No
Fiorinal	Yes	No
Ascriptin	Yes	No
Empirin	Yes	No
Alka Seltzer	Yes	No
Alka Seltzer Plus	Yes	No
Coricidin	Yes	No
Excedrin	Yes	No
Midol	Yes	No
Bufferin and others	Yes	No

Please see separate accompanying list of drugs and foods known to cause bleeding and list any taken regularly. Also, please list any other foods or drugs you feel may make you bruise easily: _____

_____

Please list any other medical problem (s) not included above:

PREVIOUS PERSONAL AND FAMILY SURGICAL HISTORY

1. **Have you had previous surgery? Please list:**

   _____

   _____

   _____

2. If so, please indicate type (s) of anesthesia as well as any complications/reactions
   - ☐ Local Anesthia _____
   - ☐ General Anesthesia _____
   - ☐ Spinal/Epidural _____
   - ☐ Sedation _____
   - ☐ Twilight Sleep _____

3. Have there been unexpected deaths or complications from anesthesia (including the dentist office) in any members of your family? ☐ Yes ☐ No Please explain _____

   _____

   _____

4. Is there a personal or family history of unexplained high fevers (known as malignant hyperthermia) following drug administration or general anesthesia?
   ☐ Yes ☐ No please explain _____

SURGICAL HISTORY - cont

5. Is there a personal or family history of unexplained high fevers following surgery?
   ☐ Yes ☐ No please explain_____

6. Is there a personal history of dark or cola-colored urine following surgery?

   ☐ Yes ☐ No please explain _____

7. Is there a personal or family history of masseter muscle rigidity (MMR)? This is a severe, sustained contracture of the jawbone muscle. ☐ Yes ☐ No please explain _____

8. Do you have a personal or family history of the following
   ☐ Scoliosis or Kyphosis (hunchbacked)_____
   ☐ Muscle disorder _____
   ☐ Spontaneous muscle cramp _____
   ☐ Squint _____
   ☐ Any other problems with muscle function _____

9. Is there anything else you think the doctor should know? _____

   _____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

MEDICARE POLICY FOR OUR PRACTICE

Effective February 1, 2012

We are writing to notify our Medicare patients of a recent decision we have made in our practice, and to explain its benefits and its impact on you. You may not know that it is voluntary for doctors to contract with Medicare. Once contracted , he/she must comply with Medicare's numerous restrictions/regulations and can be paid the fixed amount that Medicare will allow. Even if the patient desires to pay the doctor's real charges, it is prohibited by Medicare.

Doctors may choose NOT to contract with Medicare since it is a voluntary system. We have made the decision to not contract with Medicare effective February 1, 2012. We will still be offering you our medical services, but it will be outside the Medicare payment system. You will be asked to pay us directly for our services as we do with our non-Medicare patients. Due to Medicare regulations, you will receive no reimbursement from Medicare/the Federal Government.

There will be NO change in your Medicare benefits. Your Medicare benefits will remain the same, and secondary insurance benefits will continue to be in full effect for services you receive from all doctors contracted with Medicare. This change only affects our charges. There will be NO changes in our medical services to you.

You will be given a payment receipt for our services which may be useful for tax purposes, but it cannot be sent to Medicare for reimbursement. In order to be treated by us after February 1, 2012, it is necessary for you to sign below indicating that you understand our policy. We understand that some of our Medicare patients may not find this acceptable financially, and we will at your request transfer your records to a physician of your choice. We do, however, certainly hope to continue to care for you in our practice.

I, _____, understand the Medicare policy at Dr. Reed's office.

Signature:_____Dated:_____

The Reed Center For Plastic Surgery
Lawrence S. Reed, M.D.,F.A.C.S., P.C

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND KEEP A COPY OF THE REED CENTER'S PRIVACY PRACTICES.

_____ _____

Patient Signature Date

DR. LAWRENCE REED, M.D., F.A.C.S., P.C.
45 EAST 85TH STREET NEW YORK, NY 10028
(212) 772 8300

DRUGS TO AVOID BEFORE AND AFTER SURGERY- CALL OUR OFFICE IF YOU HAVE QUESTIONS!

ASPIRIN AND ASPIRIN CONTAINING COMPOUNDS

ALKA SELTZER
ANACIN
BO
BUFFERIN
CHEROCOL
COPE
CORICIDIN
DARVONCOMP
DRISTIN
EMPIRIN
EXCEDRIN
FLORINAL
MIDO
PERCODAN
ROBAXISAL
SINE-OFF
SINU-TAB
SINE-AID
STENTON
SYNALGOD-DC
TRIMINCIN
VANQUISH

ANOREXANT(REACTS WITH ADRENALINE)

TENUATE DOSPAN

ANTISPAMODIC

TENUATE

ANTIBIOTICS

FLAGYL
RYSTECLIN F
TETRACYCLINE
TOBRAMYCIN

ANTICOAGULANTS

ANTIHISTAMINES
RU-TUSS

ANALGESICS

TELFON

ZYLOPROMIN (ALLOPURINOL)

NON-STERIODALS, ANTI-INFLAMMATORIES

ANAPROX
BUTAZOLINE
CLINORIL
KUTAPRESSIN
INDOCIN
MOTRIN (ADVIL, NUPRIN)
NAPROSYN/ALEVE (5DAYS OFF)
TOLECTIN
TOLECTIN DS
ZOMAX

TRI-CYCLIN ANTI-DEPRESSANTS REACTS WITH ADRENALINE

ELAVIL
ENDEP
PAMALOR
SUPMONTIL
TOFRANIL
TRIAVIL

PHENOTHIAZINE DERIVATIVES

COMPAZINE
MELLARIL
SPARINE
STELZINE
TRILAFON

ADDITIONAL DRUGS/VITAMINS

NARDEL
PERSANTINE (CORONARY VASODILATOR)
VITAMIN E

HERBAL REMEDIES

ST JOHN'S WART
YOHIMBE
GINKO BILOBA
GINGER
GARLIC
CAYENNE
GINSENG
MELATONIN
KAVA
BLACK KOHOSH
VALERIN
FISH OIL
ASHGAWANDHA EXTRACT
GREEN TEA EXTRACT
RED YEAST EXTRACT

BIRTH CONTROL PILLS

STOP ALL BIRTH CONTROL PILLS 1 MONTH PRIOR TO SURGERY. EXAMPLES INCLUDE YAZ, GIANVI, YASMIN AND ZARAH.

DR. LAWRENCE REED, M.D., F.A.C.S., P.C.
45 EAST 85TH STREET NEW YORK, NY 10028
(212) 772 8300

OINTMENTS TO AVOID BEFORE AND AFTER SURGERY

TOPICAL MEDICATIONS CONTAINING SALICYLATE DERIVATIVES.

PLEASE CHECK ALL OTHER TOPICAL OINTMENTS, LOTIONS AND MEDICATIONS WITH STAFF

ALL MAO INHIBITORS MUST BE STOPPED 14 DAYS BEFORE SURGERY

ABSORBENT RUBS
ABSORBENT-ARTHRITIC
ABSORBINE JR
ACT - ON RUB
ACE INHIBITORS OR ARBS
ANALBALM
ANALGESIC BALM
ANTIPHLOGISTINE
ARTHRALGEN
ASPERCREME
BENAIG
BEAUMODYNE
BEN GAY
BEN GAY EXTRA STRENGHT
BENGAY GREASLESS/STAINLESS
BEN GAY ORIGINAL
COUNTERPAIN RUB
DOAN'S RUB
DIURETICS
END – AKE RUB
EXOCIANE PLUS
EXOCAINE TUBE RUB
HEAT
ICY HOT
INSULIN
INFRA-RUB
MENTHOLATUM DEEP HEATING
MINERAL ICE
MUSTEROLE REGULAR
MUSTEROLE CHILDREN STRENGTH
MUSTEROLE EXTRA
NEURABALM
OIL – O –SOL
OMEGA OIL
PANALGESIC
RID – A – PAIN
RUMARUB
SLOAN'S
SOLTICE HI – THERM
SOLTICE QUICK RUB
SPO
STIMURUB
SORIN
UNI – BALM
YAGER'S OINTMENT
ZEMO LIQUID
ZEMO LIQUID EXTRA STRENGTH
ZEMO OINTMENT

Effective Date of this Notice: 3-27-04

Office of Dr. Lawrence S. Reed, M.D., P.C., F.A.C.S
45 East 85th St, New York, New York, 10028

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

PRIVACY OFFICER, Office of Dr. Lawrence S. Reed
45 EAST 85TH STREET, NYC, 10028
1-212-772-8300

Effective Date of this Notice: 3-27-04

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH. INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range-of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use *your* IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL:
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:
6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or

the description, identity or location of the perpetrator)

OPTIONAL:
5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:
6. Organ and Tissue Donation. Our practice may release your IIHII to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:
7. Research.. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances, We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PBI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PBI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of US. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order *to protect* the President, other officials or foreign heads *of* state, or *to* conduct investigations.

11. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

Effective Date of this Notice: 3-27-04

E. YOUR RIGHTS *REGARDING* YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Privacy Officer, Office of Dr. Lawrence S. Reed, 45 E. 85th St., New York, NY 10028; 212-772-8300 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI; you must make your request in writing to: Privacy Officer, Office of Dr. Lawrence S. Reed, 45 E. 85th St., New York, NY 10028; 212-772-8300. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer, Dr. Lawrence S. Reed,45 E.85th St., New York, NY 10028; 1-212-772-8300 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health intonation if you believe it is incorrect or incomplete, and you may request an amendment for as long as the infom1ation is kept by or for our practice, To request an amendment, your request must be made in writing and submitted to Privacy Officer, Dr. Lawrence S. Reed, 45 E. 85th St., New York, NY 10028; 1-212-772-8300. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the intonation is not available to amend the intonation.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer, Lawrence S. Reed, M.D., 45 E.85th St., New York, NY 10028; 1-212-772-8300. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Privacy Officer, Dr. Lawrence S. Reed, 45 E. 85th St., New York, NY 10028; phone, 1-212-772-8300.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Privacy Officer, Dr. Lawrence S. Reed, 45 E. 85th St., New York, NY 10028; 1-212-772-8300. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use 91' disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Privacy Officer; Dr. Lawrence S. Reed, 45 E.85th St., New York, NY 10028 phone: 1-212-772-8300.