Internal Medicine Physicians (IMP)

Welcome to Internal Medicine Physicians (IMP). We have three locations and six providers working to be your Patient Centered Medical Home. The enclosed information is provided to help familiarize you with our practice.

Our locations:

1207 West State St., Ste N, Alliance, Ohio 44601	(330) 821-3244	Fax: (330) 868-5782
1168 Alliance Rd. NW, Minerva, Ohio 44657	(330) 868-3711	Fax: (330) 868-5782
4080 Holiday St. NW., Canton, Ohio 44718	(330) 492-8117	Fax: (330) 868-5782

Our Providers	**Specialty**
Mark E. Hostettler, M.D.	Board Certified in Internal Medicine
David B. Kimbell, M.D.	Board Certified in Internal Medicine
Pamela A. Rodocoy, M.D.	Board Certified in Internal Medicine
Matthew S. Gooch, APRN	Advanced Practice Registered Nurse
Jacquelyn M. Dennis, APRN	Advanced Practice Registered Nurse
Geona F. Guappone, APRN	Advanced Practice Registered Nurse
Quinn M. Repp, PA-C	Physician Assistant, Certified

PAYMENT POLICY

Our policy is to collect copayments at the time service is rendered. We will bill your health insurance company for our services. After your insurance processes our claim, you will receive a statement for any coinsurance or deductible amounts. If you have no insurance, you are responsible for paying the entire amount of your visit at the time of service. We accept Cash, Check, Debit Card, American Express, Discover, MasterCard, and Visa.

Please check with your insurance company for your specific information.

***Co-Payment*:** A cost sharing amount of your insurance plan. This is usually a fixed dollar amount designated by your insurance company, that is your responsibility to pay at each visit (also known as co-pay).

***Deductible*:** The amount of cost sharing that you must pay for medical services rendered, often before your health insurance company begins to pay.

***Co-Insurance*:** The part of your bill, in addition to the co-payment, that your insurance plan requires you to pay. This is usually a percentage of the total medical bill; for example, 20 percent.

APPOINTMENTS

New Patient vs Annual Physical/Wellness visit. The new patient visit will not be billed to your insurance company as an Annual Physical or Wellness visit. The New Patient appointment is for your new primary care physician to review your past medical history and family history with you to determine immediate care needs and/or appropriate testing to be ordered for your Annual Physical or Wellness visit.

***Arrival time*:** We ask that you arrive at least 20 minutes prior to your scheduled New Patient appointment to begin the intake process. When arriving, please have photo ID, insurance card(s), copayment and completed New Patient forms ready. This will prevent delays and/or rescheduling of your appointment. We reserve the right to reschedule this or any future appointments if you arrive 10 or more minutes late for your scheduled appointment time.

***Cancelling/Rescheduling*:** To provide the best care for all our patients, we ask that you provide at least 24-hour advance notice to cancel or reschedule this or any future appointments. Please note, a New Patient visit will not be rescheduled if at least 24-hour notice is not received.

Please complete the enclosed Health Questionnaire and bring it with you to your appointment. If you have questions about any of the information included, our staff will be happy to help you. We appreciate you selecting Internal Medicine Physicians for your medical care and will work hard to serve your needs.

Sincerely,
IMP Providers and Staff

NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ Today's Date _____

Name patient uses: _____ Date of Birth _____

Demographic Information			
Preferred Language:			
Race:	☐ White	☐ African American	
Ethnicity:	☐ Hispanic/Latino/Spanish	☐ Not Hispanic or Latino	
Relationship Status:	☐ Single	☐ Widowed	☐ Domestic Partner
	☐ Married	☐ Divorced	
Do you have children?	☐ No	☐ Yes Number	
How do you identify	☐ Choose not to disclose	☐ Straight or Heterosexual	☐ Bisexual
your sexual orientation?	☐ Unknown	☐ Lesbian, Gay, or Homosexual	☐ Something else
Gender Identity:	☐ identifies as male	☐ transgender male (female to male)	☐ choose not to disclose
	☐ identifies as female	☐ transgender female (male to female)	☐ other gender category
Assigned sex at birth:	☐ male	☐ female	☐ choose not to disclose
Pronouns:	☐ he/him	☐ she/her	☐ they/them

Where would you like your prescriptions filled? Please provide pharmacy name and address.	
Local Pharmacy:	Mail-Order Pharmacy:
Address:	Address:

List other medical professionals involved in your care.			
	Name	Phone Number	Reason for Specialist
Dentist			
Eye Doctor			
Gynecologist			
Other Specialist			
Other Specialist			
Other Specialist			

Allergies/Intolerances			
Allergen Name	Reaction	Intolerance or Allergy	Start Date
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	

MEDICATIONS: List all prescription medications you currently take. Use additional paper if necessary.				
Medication	Strength	How Often	Start Date	Reason

SUPPLEMENTS: List vitamins, hormones, alternative remedies, or over-the-counter medications you use.				
Supplement	Strength	How Often	Start Date	Reason

IMMUNIZATIONS: List date of last injection. (PLEASE BRING ANY IMMUNIZATION RECORDS WITH YOU)					
Name	Date(s)	Name	Date(s)	Name	Date(s)
Tetanus		Hepatitis A		Pneumonia-Prevnar	
Tdap		Hepatitis B		Pneumovax 23	
Polio		Typhoid		Zostavax	
MMR		Gardasil		Shingrix	
Meningitis		Influenza		COVID-19	

FAMILY HISTORY

Family History: Follow lines across the page for each person and check the appropriate boxes.	Alcoholism	Anemia	Arthritis	Asthma/Lung disease	Cancer	Diabetes	Gout	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Migraine	Seizures	Stroke	Tuberculosis	other
Father																	
Paternal GM																	
Paternal GF																	
Mother																	
Maternal GM																	
Maternal GF																	
☐ Brother ☐ Sister																	
☐ Brother ☐ Sister																	

SOCIAL HISTORY

Tobacco Smoking Status:

☐ Never smoked ☐ Former smoker ☐ Current Every Day smoker ☐ Current Some days smoker

Smoking- How much?

☐ 1PPW ☐ 2PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1 PPD ☐ 1½ PPD ☐ 2 PPD ☐ 3+ PPD

Smokeless Tobacco Status:

☐ Never used smokeless tobacco ☐ Former smokeless tobacco user

☐ Current snuff user ☐ Currently chews tobacco ☐ Currently uses moist powdered tobacco

E-cigarette/vape status: ☐ Never used E-cigarettes ☐ Current user of E-cigarettes

☐ Former user of E-cigarettes

Tobacco years of use _____

Most recent tobacco use screening _____

SOCIAL HISTORY continued					
Deaf or serious difficulty hearing			☐ Yes	☐ No	
Blind or serious difficulty seeing			☐ Yes	☐ No	
Difficulty concentrating, remembering, or making decisions			☐ Yes	☐ No	
Difficulty walking or climbing stairs			☐ Yes	☐ No	
Difficulty dressing or bathing			☐ Yes	☐ No	
Difficulty doing errands alone			☐ Yes	☐ No	
Able to care for self			☐ Yes	☐ No	
Do you have Advanced Directives?		☐ Durable Power of Attorney		☐ Living Will	
		☐ Healthcare Power of Attorney		☐ DNR or DNRCC	
(PLEASE BRING YOUR ADVANCED DIRECTIVES TO THE OFFICE TO BE COPIED & PLACED IN YOUR CHART.)					
Live alone or with others			☐ alone	☐ with others	
Dental care within the last 12 months			☐ Yes	☐ No	
Transportation difficulties			☐ Yes	☐ No	
Social support system:					
Difficulty making ends meet at the end of the month			☐ Yes	☐ No	
Highest grade or level of school completed or highest degree received:					
How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?					
On the days you engage in moderate-strenuous exercise, how many minutes on average do you exercise?					
How hard is it for you to pay for the basics like food, housing, medical care, and heating?					
☐ very hard	☐ hard	☐ somewhat hard	☐ not very hard	☐ decline to answer	
Do you feel stress- tense, restless, nervous, anxious, or unable to sleep at night because your mind is troubled					
all the time - these days?		☐ not at all	☐ only a little	☐ to some extent	
		☐ rather much	☐ very much	☐ decline to answer	
Alcohol intake:	☐ none	☐ occasional	☐ moderate	☐ heavy	
Caffeine intake	☐ none	☐ occasional	☐ moderate	☐ heavy	
Do you now or have you ever had a problem with drug use?			☐ Yes	☐ No	Type:
Occupation:		☐ Retired	☐ Unemployed	☐ Permanently disabled	
Exercise level	☐ none	☐ occasional	☐ moderate	☐ heavy	
Single or multi-level home/work		☐ single level home	☐ single level work		
		☐ multi-level home	☐ multi-level work		
Marital status	☐ single	☐ married	☐ separated	☐ divorced	☐ widowed ☐ domestic partner
Ambulatory?	☐ walks without assistance		☐ requires minimal help in wheelchair		
	☐ walks with an assistive device		☐ Limited self-mobility with assistive device		
	☐ independent in wheelchair		☐ dependent on helper pushing wheelchair		

PAST SURGERIES/PROCEDURES/HOSPITALIZATIONS			
Type	Approx. Date	Type	Approx. Date

HEALTH HISTORY: Are you being treated or have you ever been treated for any of the following?

Please check if applicable. Additional space is provided below for details or other health conditions not listed.

- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
  Type _____
- ☐ Carotid Stenosis
- ☐ Colonic Polyp
- ☐ COPD
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis/Diverticulosis
- ☐ DVT/Pulmonary Embolism
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart Disease
  - __ Heart rhythm issue
  - __ Stents/Surgery
  - __ Pacemaker/Defibrillator
  - __ Heart Valve
  - __ Congestive Heart Failure
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Migraine
- ☐ Neuropathy
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's
- ☐ Peripheral vascular disease
- ☐ Prostate disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis/Lupus
- ☐ Seizure disorder
- ☐ Spinal disease
- ☐ Stroke
- ☐ Valvular Heart Disease

PREVENTIVE CARE

	date of last	Physician	Facility/Office Location
Colonoscopy or Cologuard			
Upper GI/ Endoscopy/EGD			
Mammogram			
DEXA (Bone Density)			
Dental Exam			
Eye Exam			
Male Patients	**date of last**	**Female Patients**	**date of last**
PSA Laboratory		Breast examination	
Rectal/Prostate exam		Pap smear	
Testicular exam		Rectal exam	

ADDITIONAL COMMENTS OR INFORMATION:

Patient Signature _____ Date _____

Guardian/POA Signature (if applicable) _____ Guardian/POA Printed Name (if applicable) _____

IMPhysicians
The Future of Healthcare

Requesting Your Medical Records

As a convenience to you, we will request your medical records from your previous physician on your behalf.

Please fill in your previous provider's Name and Phone number and/or fax number on the ***Authorization for Use or Disclosure of Protected Health Information Form***. Bring it to your new patient appointment and we will fax to them for you.

***Note:** We do not advise having your medical records transferred to us in advance of your New Patient appointment. Should you need medical attention or a medication refill prior to your first visit with us, you would need to contact them.

IMPhysicians
The Future of Healthcare

Authorization for Use or Disclosure of Protected Health Information

I, (patient name) _____, (date of birth)____/____/____,
hereby authorize Internal Medicine Physicians:

☑ to **request** my personal health information (PHI)

- Visit notes from the past 12 months
- Most recent Labs and Imaging
- Diabetic Eye Exam
- Colorectal Cancer Screening
- Mammogram
- Pap Test

☑ from my Previous Provider:

Name: _____ Phone # _____

Address: _____ Fax # _____

Records cannot be accepted on CD/flash drive
Please fax records to our Centralized Fax Number (330) 868-5782

The minimum necessary of the above items of PHI being released and/or received is being used or disclosed for the following purpose: **Transfer of patient's Primary Care**

I understand and acknowledge that the requested health information may contain information regarding physical and mental illness including, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below. *Release of Psychotherapy Notes requires a separate authorization.

This authorization shall be in force and effect until (specify date or event that relates to the patient or the purpose of the use or disclosure) **1 year from date of patient signature** at which time this authorization to use or disclose this PHI expires.

I understand that I have the right to revoke this authorization in writing at any time by ending such written notification to Administrator at Internal Medicine Physicians. I understand that a revocation is not effective to the extent that Internal Medicine Physicians has relied on the use or disclosure of the PHI.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
Internal Medicine Physicians will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization upon request.

_____ _____
Printed Name of Patient or Personal Representative | Description of Personal Representative Authority

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Witness | Date

MPhysicians
The Future of Healthcare

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

Medical Information Release Form (HIPAA Release)

This form may be used to designate an emergency contact and/or anyone you would like us to be able to speak with on your behalf. You may revoke this authorization at any time.

Name: _____ Date of Birth _____

Release of Information

☐ I authorize the release of my protected health information including appointment dates and times, diagnoses, records, examinations rendered to me, and claims information examinations. This information may be released to:

☐ Spouse _____ Phone # _____

☐ Child _____ Phone # _____

☐ Other _____ Phone # _____

☐ Use only in case of emergency

☐ I do not give authorize to release my protected health information.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call my ☐ home ☐ work ☐ cell. Phone number: _____

Signature: _____ Date: _____

IMP Physicians
The Future of Healthcare

Patient Notice of Office Policies

It is illegal to carry a firearm, deadly weapon, or dangerous ordnance anywhere on these premises. Unless otherwise authorized by law, no person shall knowingly possess, have under the person's control, convey, or attempt to convey a deadly weapon, or dangerous ordnance onto these premises, pursuant to Ohio Revised Code.

IMP is a smoke/tobacco/vape free environment.

Identification & Insurance Information: Patients will be asked to present insurance card(s) and photo identification at every visit. This not only keeps the practice in compliance with insurance company requirements, but also helps to protect your healthcare identity.

Arriving Late: Patients arriving ten (10) or more minutes late for an appointment may be asked to reschedule.

Broken Appointments: IMP is able to send appointment reminders via email, phone or text. Inform the office staff which method of communication you prefer. Appointment reminders are a courtesy; the patient bears all responsibility for knowing their scheduled appointment dates and times. When a patient fails to show up or provide advance notice of the need to cancel or reschedule, they are taking away time another patient may have needed. For this reason, IMP requires a minimum of 24 hours advance notice to cancel or move any scheduled appointment. A $60 broken appointment fee will be charged if the minimum 24-hour advance notice is not received. IMP reserves the right to terminate the patient-provider relationship if three or more broken appointments occur. *Please note, our answering service is staffed by RNs for management of medical issues; they do not handle appointments or cancellations.*

Workers' Compensation: We are NOT certified by Workers Compensation and cannot provide services for any work-related injuries.

Motor Vehicle Accidents (MVA): It is the patient's responsibility to notify IMP prior to or upon arrival when any service may be related to a motor vehicle accident. Services related to an MVA are covered by auto insurance rather than health insurance and IMP is unable to bill an auto insurance company. We will collect payment in full at the time of the visit and will provide all documentation necessary for the patient to submit a claim to the auto insurance company.

Medical Information: Patients may request IMP staff provide copies of visit notes or results of tests ordered by their provider. Patients also have the option of creating a portal account for access to their own medical records at any time.

Prescription Refills: It is most efficient to request refills through the pharmacy. The pharmacy will electronically request approval from the patient's primary care provider at IMP. Every effort is made to complete a refill request within the same day. Controlled medications cannot be refilled prior to the due date.
*** N**o refills will be processed for a patient not seen within 12 months of the refill request.

Laboratory Services: **It is the responsibility of the patient to know which laboratories are in-network with their health care plan.** Using an out-of-network laboratory will result in higher out of pocket costs for the patient. Patients should contact their insurance company to obtain this information. IMP is not responsible for laboratory billing.

Forms of Payment: IMP accepts cash, checks, debit cards and the following credit cards: American Express, Discover, Mastercard and Visa. Post-dated checks are NOT accepted.

Copayments (Copay): Copayments are collected at the time of service per insurance company contract. Copays that are not paid at the time of service may incur an additional $10.00 statement fee which is not covered by the insurance plan. This fee covers the expense of collecting the copayment at a later date. Patients are responsible for knowing their copayment amount and having it with them at the time of the appointment.

Phone Management Fee: IMP maintains the right to charge a $20.00 fee for managing and treating minor issues over the telephone. The phone management fee is not billed to the healthcare plan and is therefore the full responsibility of the patient. The phone management fee is separate from and does not apply to scheduled telehealth visits.

Form Completion Fee: A $20.00 fee will be charged for completion of forms and is payable when the form is brought in to the office.

NSF Fee: A $40.00 fee will be applied to the account of patients who have a check returned for any reason including insufficient funds.

Delinquent Accounts: Our billing department routinely reviews accounts with past due balances that are the patient's responsibility. Once an account becomes delinquent, a letter notifying the patient will be sent. Payment in full is expected upon receipt of such a letter unless other arrangements are made with our office. Payment plans can be arranged if payment in full is not possible. If the account remains delinquent, it will be turned over to a collection agency at which time, interest will accrue on the balance due. If an account is sent to collections, all scheduled appointments will be cancelled. The practice maintains the right to terminate the patient from the practice. IMP understands that at times temporary financial problems may affect the timely payment of your account. For this reason, we encourage the patient contact our Practice Manager. IMP will do everything possible to keep our relationship in good standing.

Refunds: A credit balance of less than $10.00 will remain on the patient's account and applied to future visits unless a refund is requested by the patient.

Notice of Office Policies: I acknowledge receipt and agree to the Office Policies of Internal Medicine Physicians.

Notice of Privacy Practices for Protected Health Information: A copy of the Internal Medicine Physicians' Notice of Privacy Practices has been offered to me. I understand that my protected health information may be used by Internal Medicine Physicians as described in the notice.

Patient Responsibility: I agree that I am responsible for my actions if I refuse treatment or do not follow the health care provider's instructions. I agree that I am responsible for providing needed information for insurance billing.

Financial Policy: I understand my insurance policy is a contract between my insurance company and myself and that I am ultimately responsible for the entire bill. I understand that any fees are based on treatment received and have no bearing on outcome. I hereby authorize payment directly to Internal Medicine Physicians for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by the provider. I understand I am financially responsible for any professional charges not paid by my insurance company to Internal Medicine Physicians.

This is your copy of our Office Policies.

You will be asked to sign an acknowledgement of receipt when you arrive for your appointment.

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS NOTICE CAREFULLY; OUR OFFICE WILL REQUIRE YOU TO ACKNOWLEDGE THAT YOU UNDERSTAND AND HAVE REVIEWED THIS PRIVACY POLICY.

THIS NOTICE EXPLAINS HOW MEDICAL I NFORMATION MAY AND CAN BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

Internal Medicine Physicians will release medical chart information as necessary or as requested to make sure you receive quality healthcare and to receive reimbursement for those services. This office is required by law to maintain privacy for our patients' health and personal information and to provide you, our patient, with this notice. This office will follow your instructions as to the release of any health and demographic information in your medical chart.

HOW WE MIGHT USE AND DISCLOSE MEDICAL INFORMATION

For Treatment: We will use medical information about you to provide medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other office personnel who are involved in taking care of you. For example, we would disclose your health information, as necessary, to a home health agency that provides care to you. We may also disclose medical information about you to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.

For Health Operations: We will use and disclose medical information about you for our operations. These uses and disclosures are necessary to run our office and ensure all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other office personnel for review and learning purposes. We may also call you by name in the waiting room when your physician is ready to see you.

For Treatment Alternatives: We might use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. If necessary, we will use and disclose medical information about you to facilitate organ and tissue donation.

For Payment: We will use and disclose medical information about you so that treatment and services we provide may be billed to and payment may be collected from you, an insurance company, a governmental entity such as Medicare or Medicaid, or a third party. For example, we may need to give your health plan information about treatment we provide so your health plan will pay us or reimburse you for the treatment.

For Business Associates: We contract with business associates to provide some services. Examples may include medical billing and collection services. When these services are contracted, we may/will disclose your health information so they may perform the job we have asked them to do. To protect your health information however, we require the business associate to appropriately safeguard your information. Other outside entities could include an insurance request for information to process your claim or for risk management purposes. This will consist of either a copy of your chart being forwarded or a representative of such company personally reviewing your chart.

Also:

To achieve continued or concurrent care (whether hospital or another physician), as deemed necessary by your physician at Internal Medicine Physicians. In case of emergency and you are unable to communicate with your physician, this information could be released without your permission to family and friends who are involved in your medical care. Appointment reminders or change of appointment utilizing a letter or a phone call (leaving a message on your answering machine or voice mail, if applicable).

When necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

As required by law when required to do so by federal, state, or local law. This would include, but is not limited to, Workers Compensation and public health information.

Transfer of records to another physician for your continued care. If you choose to leave our practice, we will require a Signed Release of Information, signed and dated by you. Appropriate fees for transfer of records must be collected from you.

YOU HAVE RIGHTS REGARDING THIS INFORMATION

- You have the right to place restrictions on the release of this information. Such restrictions must be made in writing, signed and dated by you. This request must be sent to the attention of the Practice Manager.
- Termination of this agreement is also your right and written notice of such can be forwarded to the Practice Manager.
- You have the right to inspect your medical chart and obtain a copy of such chart that is securely kept in the office. A charge of $15.00 must be pad at this time.
- You have the right to make amendments to your chart by written request to this office. Such amendments will be treated as an addendum to your medical chart and not as a replacement entry.
- You have the right to expect and ask for an accounting of the release of your information.

BREACH OF UNSECURED HEALTH INFORMATION:

If the security office determines there has been a breach of unsecured PHI, Internal Medicine Physicians is required to notify you of the breach.

VIOLATIONS OF YOUR PRIVACY RIGHTS:

If you feel that your rights have been violated, you may file a complaint with the Practice Manager: 1207 W. State St., Ste N, Alliance, OH 44601. Phone 330-821-3244.

You may file a complaint with the Secretary of the United States Department of Health and Human Services in Washington D.C.

INTERNAL MEDICINE PHYSICIANS WILL ENDEAVOR TO MAINTAIN THE CONFIDENTIALITY OF YOUR MEDICAL INFORMATION IN EVERY SITUATION AS PER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) WHICH WENT INTO EFFECT 4/13/03.