Welcome!

1. Please bring this **COMPLETED** packet to your appointment. Your appointment is 1 hour long and the paperwork takes about 25 minutes to complete, so please have your paperwork completed.
2. The office can be tricky to find first time around, so be sure to **READ DIRECTIONS** carefully. Look on the map for the pin point.

The office is located in the 2350 Washtenaw Building, located at the Y where Washtenaw splits into Stadium Blvd (there is a Bearclaw Coffee Co. at the point of the Y). Our office is on the **LOWER** level.

From US 23 - take the Washtenaw Ave/Ann Arbor Exit (37B). As you approach the 5th traffic light move into the lane added on the right (following overhead sign for Washtenaw Ave). Stay in the right lane, and follow Washtenaw Ave as it bears right (northwest) immediately after the light. The second driveway on the left is our building (look for 2350 on the top corner of the building). Parking from Washtenaw entrance will put you on the second level, please come down the stairs to the lower level, suite 24.

If you are entering from Stadium Blvd. - Please turn in at King's Keyboard and follow the drive up and to the left. We will be the first building on the right at the far end, suite 24.

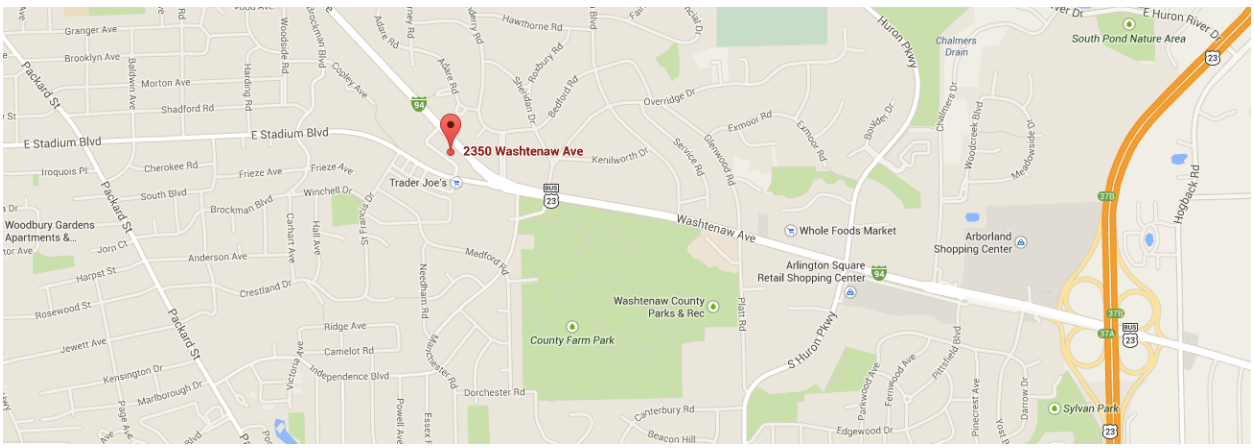
- Your child must have another healthcare practitioner to meet their primary care needs: urgent/emergent sick care, 24-hour phone coverage and well child visits (including health and/or sport physicals).
- If you're bringing more than one child, each child requires a 1-hour appointment slot to ensure ample time for premium care.
- A detailed receipt will be provided at the end of the appointment that can be submitted to your health insurance should they allow that.

I look forward to meeting you and your child very soon!

Blessings,

Dr. Sue

Susan McCreadie, MD



Who may we thank for referring you?_____ **Today's Date:** ____/____/____

Please list child being seen FIRST followed by ALL of his/her siblings

Name (First Middle and Last)	**Sex** (M / F)	**Date of Birth** (Mo/Day/Yr)

Parent Information	**Mother**	**Father**
Name (First and Last)		
Date of Birth (Mo/Day/Yr)		
Address (Street)		Leave Blank if Same
Address (City, State, Zip)		Leave Blank if Same
Employer		
Occupation		
Preferred Phone #		Leave Blank if Same
Email		Leave Blank if Same

Emergency Contact Information (whose residence is different from yours)	
Name (First and Last)	
Relationship to Patient	
Address (Street, City, State, Zip)	
Preferred Phone #	

Primary Care Physician Information	
Name	
Address (Street, City, State, Zip)	
Phone #	

Insurance Policy
Dr. McCreadie is out-of-Network for ALL insurance companies. Payment is due at time of service. Paperwork to submit health insurance provided at each visit.

I, the parent who requests treatment for the child, am financially responsible for the fee of all services rendered. I understand that past due accounts will be transferred to a collection agency and any such accounts will be assessed a thirty percent (30%) collection fee based upon the balance on the account. I shall be responsible for payment of the balance of my account, plus the thirty percent (30%) collection fee. I also will be responsible for all other costs of collection including reasonable attorneys' fees and court costs.

Print Name of Parent who requests treatment for child

Signature of Parent who requests treatment for child

Relationship (mother, father, other)

Date (Mo/Day/Yr)

Cancellation Policy

Pediatric Holistic Medicine, P.L.C. has a policy of charging a fee for missing an appointment, or canceling an appointment with less than one working day's notice. The fee is $50.00. The responsible party for the patient [the parent requesting treatment for the child] will be liable for cancellations of convenience or cancellations due to a last minute schedule conflict. Family crises are exempt. The purpose of this fee is to encourage parents to take their child's scheduled appointment time sincerely. Time is reserved for your child. If your child's appointment is not kept, other patients who need earlier appointments than the schedule permits are obliged to wait longer than necessary. Full cooperation is expected. I have been given an opportunity to review and discuss Pediatric Holistic Medicine, P.L.C.'s Cancellation Policy.

Print Name of Parent who requests treatment for child

Signature of Parent who requests treatment for child

Relationship (mother, father, other)

Date (Mo/Day/Yr)

Receipt of Notice of Privacy Practices

I have received a copy of Pediatric Holistic Medicine, P.L.C.'s Notice of Privacy Practices.

Print Name of Parent who requests treatment for child

Signature of Parent who requests treatment for child

Relationship (mother, father, other)

Date (Mo/Day/Yr)

Consent to Treatment - BY SIGNING BELOW, I UNDERSTAND, ACKNOWLEDGE AND AGREE THAT:

1. Dr. Susan McCreadie and Pediatric Holistic Medicine, P.L.C. (PHM) use a holistic approach to the practice of medicine. This means they follow a philosophy that integrates complementary medical services, such as medical acupuncture, craniosacral therapy, homeopathy, neuro-emotional technique, and reiki with traditional/conventional medicine approaches, in an effort to benefit a patient's mind, body and spirit.

2. I will discuss with Dr. McCreadie any questions I have about her care philosophy and the care philosophy of PHM.

3. Complementary based healing practices use and involve diagnostic and treatment methods that are considered experimental or investigational. These practices are intended to complement and are not a substitute for traditional/conventional medicine approaches.

4. As with traditional/conventional medicine practices, there are potential risks and potential benefits associated with complementary and integrative medicine. Dr. McCreadie will discuss the potential benefits and significant, known potential risks associated with the treatment she offers, as well as conventional/traditional only treatment alternatives. I will discuss with Dr. McCreadie any questions I have with regard to those potential benefits and risks, as well as any questions I have with respect to the risks and benefits associated with non-treatment or following a conventional/traditional only treatment regimen.

5. Dr. McCreadie and PHM do not guarantee the result of care or services they provide.

6. Dr. McCreadie provides services as a consulting pediatrician and not as a primary care physician. As a result, she will not serve as the primary care physician for the minor child identified as the patient below. I will obtain the services of a primary care physician for the minor child identified as the patient below.

7. Because she does not practice as a primary care physician, Dr. McCreadie is available during regularly scheduled office hours, and she is not on call, and not available, on a 24 hour, 7 day per week basis as is the case with primary care physicians.

8. I understand for Dr. McCreadie to provide phone consultation services, my child must be seen in the office for the initial visit and at least once in a 6 month period, or more often as recommended by Dr. McCreadie in her professional judgment. If more than 6 months has elapsed since my child's last in-office visit, I understand my child will need to be seen prior to Dr. McCreadie doing another phone consultation.

9. As is the case with the medical records of the minor child identified as the patient below, I am entitled to request a copy of this Consent to Treatment. I will be charged the fee that is permitted by applicable law for copies of information I request.

10. If I have any questions with regard to the content of this Consent to Treatment, I will discuss them with Dr. McCreadie before signing it.

11. I understand this Consent to Treatment will remain in effect until withdrawn. I may withdraw this Consent to Treatment at any time by providing notice of the withdrawal to Dr. McCreadie and PHM.

I have read completely, and agree to, the statements contained in this Consent to Treatment, and I freely and voluntarily seek and consent to receiving services from Pediatric Holistic Medicine, P.L.C. and Dr. McCreadie.

Print Name of Parent who requests treatment for child

Signature of Parent who requests treatment for child

Print Name of Child

Date (Mo/Day/Yr)

INITIAL HISTORY QUESTIONNAIRE

/ /

Patient Name Birthdate

REASONS FOR TODAY'S EVALUATION

If I could wave a magical wand and make 3 issues disappear, what would they be?

1._____

_____

2._____

_____

3._____

_____

What steps/methods have been taken to correct these issues? ☐None_____

_____

Do these interfere with the child's sleep, eating, or daily activities? ☐Yes ☐No

Describe: _____

MEDICAL HISTORY

Birth History

Were there any complications during pregnancy? ☐No ☐Yes (Check all that apply)

☐Bleeding
☐Diabetes
☐Nausea, severe morning sickness, or poor nutritional status
☐Infectious Diseases / Sexually transmitted illness
☐Physical or emotional trauma
☐Hypertension
☐Thyroid or other endocrine problems
☐Other_____

Birth interventions: ☐Forceps ☐Vacuum ☐Induction ☐Caesarian (Planned or Emergency) ☐None

Explain:_____

☐ Passed Newborn Hearing Screen & State Screen

Were any medications (antibiotics, steroids, vaccines) given during pregnancy? ☐No ☐Yes

List:_____

Breast fed: ☐No ☐Yes How long?_____

Formula fed: ☐No ☐Yes ☐Milk ☐Soy How long?_____

Were there any concerns about the prenatal, birth, or infancy period that were not addressed above? ☐No ☐Yes

Explain:_____

Allergies: Please list all known food, environmental or medication/chemical allergies/sensitivities and their reactions

Medication/Chemical Allergies: ☐None_____

Environmental Allergies: ☐None_____

Food Allergies/Sensitivities: ☐None_____

Nutrition/Diet History

Please check foods that are typically included in the child's diet:

☐ Milk [cow/breast/formula]	☐Water	☐Juice	☐Soda/Pop	☐Coffee	☐Grains
☐ Vegetables	☐ Fruits	☐ Meat	☐Poultry	☐Fish	☐Legumes
☐ Eggs	☐Nuts	☐ Yogurt	☐Cheese	☐Sugar	

☐ Other _____

Special Dietary Restrictions: ☐None

Immunization History: □ Copy of immunization record provided

Has your child followed the recommended immunization schedule? □ No □ Yes □ Partial
Describe_____
Has your child had any reactions to immunizations? (allergic, developmental, behavioral, etc…)
Describe? □ None_____

Gynecological History *[For menstruating females]* □ Not Applicable
Age [years] of first menstrual period ____ Last menstrual period ____/____/____ Average cycle length [days] ____
Problems with menstruation: _____

Medications **Please list all of your current medications** and supplements and their doses or check □ None

MEDICATIONS	DOSAGE	TIMES/DAY	STARTED	ORDER BY	PURPOSE
(ex.) Ritalin	*20 mg*	*2*	*Jan/07*	*(physician)*	*attention*
SUPPLEMENTS/ OTHER					
(ex.)Vitamin D	*400mg*	*1*	*2006*	*(none/myself)*	*supplement*

If you have any allergies to a specific medication, please list and describe above under Allergies section.

MAJOR EVENTS, HOSPITALIZATIONS, OR SURGERY
Has your child ever been to the emergency room? □ No □ Yes
Why? _____
When? _____
What was done? _____

Has your child ever had a serious accident or injury? (fallen down stairs, broken bone, fallen head first, sports injury, etc.…) □ No
If yes, describe? _____

Please list all major/minor surgeries your child has had and their approximate dates. □ None

_____
_____
_____

DEVELOPMENT HISTORY
Is/Has your child reach developmental milestones within a reasonable time frame? □ No □ Yes
Physical growth delays/concerns:_____
_____
Motor/Language/Social/Emotional Developmental delays/concerns: □ None_____
_____

REVIEW OF SYSTEMS

Please circle and explain in the space provided if your child has had any problems related to the following:

***General*:** fevers, chills, excessive sweating, unexplained weight loss/gain

***Eyes*:** squinting, “crossed” eyes, itchy or watery eyes, difficulty targeting objects

***Ears/Nose/Throat*:** difficulty hearing, frequent ear pulling, runny nose, problems with teeth/gums, snoring

***Skin*:** body rash, rashes or redness around the anus, eczema, dry skin, unusual marks or moles

***Neurological*:** headaches, weakness, shaking or tremors, staring spells, speech problems

Musculoskeletal: limping, muscle or joint pain, favoring one limb, delayed milestones, asymmetries

Cardiovascular: tires easily with exertion, shortness of breath, heart murmurs, fainting, dizziness

***Blood/Lymph*:** anemia, unexplained lumps on the body, easy bruising/bleeding

Respiratory: cough/wheeze, chest pain, nasal flaring, use of neck muscles to breath

Gastrointestinal: nausea, vomiting, reflux, diarrhea, bloating, constipation, belly pain, stool abnormalities

***Genitourinary*:** bedwetting, pain with urination, discharge from penis or vagina, urine abnormalities

Behavioral: hyperactivity, irritability, sleep issues, nail biting, excessive tantrums, anxiety, depression

FAMILY HEALTH HISTORY

Please check all that apply:

	Mother	Father	Sister/Brother	Grandparents	Other(Aunt, uncle, cousins)
Allergies					
Asthma					
Arthritis					
Birth defects					
Immune problems					
Mental Illness					
Anemia					
Bleeding disorder					
High cholesterol					
Heart disease					
High blood pressure					
Diabetes					
Liver disease					
Kidney disease					
Seizures					
Hearing/Vision					
Developmental delay					
Substance abuse					
Cancer					
Other					

ACTIVITY and SLEEP HISTORY

Favorite activities:_____
Hours spent per day:_____
☐ Physical activity _____ ☐ Watching TV_____ ☐ On Computer/Video games _____
☐ Other _____

Are there any concerns about your child's sleeping pattern? ☐ No ☐ Yes # hours/night:_____

If Yes, describe_____

Is quality of sleep? ☐ Good ☐ Fair ☐ Poor?_____

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐ No ☐ Yes
Current grade: _____
Sports/extracurricular activities: Type_____
How often?_____
Any concerns about school performance? ☐ No ☐ Yes
☐ Academic difficulties ☐ Repeated grades ☐ Resource help/tutoring ☐ Academic performance ☐ Other
If other, please explain:
Any concerns about relationship with Teachers? ☐ No ☐ Yes,
Any concerns about relationship with Peers? ☐ No ☐ Yes,
Has your child ever been evaluated by a school diagnostic team: ☐ No ☐ Yes
If yes, what were the results?_____
Does your child receive special services from the school? ☐ No ☐ Yes
Explain: _____
_____
Does your child receive private special services? ☐ No ☐ Yes
Explain: _____
_____

SOCIAL HISTORY

Household Who lives in household (people/pets)? _____
If divorced or separated, when?_____ Custody: _____
Child care situation _____
Household exposures: ☐ Smoking ☐ Substance abuse ☐ Domestic violence ☐ None
Describe:_____
Family support structure: ☐ Family ☐ Friends ☐ Church ☐ Other
Describe: _____
Any other concerns (if age appropriate)? ☐ None
Alcohol/Drug use: ☐ No ☐ Yes Tobacco: ☐ No ☐ Yes Sexual activity: ☐ No ☐ Yes Aggressive behavior: ☐ No ☐ Yes

Sexual History *[For sexually active males and females]* ☐ Not Applicable
History of sexually transmitted disease: ☐ No ☐ Yes Sex of partner[s]: ☐ Male / ☐ Female Number of partners_____

OTHER

Please provide any other information that you think will aid in the treatment of your child: ☐ None
_____
_____
_____
_____
_____

Physician Notes/ Physical exam findings:
_____
_____

Reviewed History with parent/guardian_____ Date: _____
Susan G. McCreadie, MD _____

Pediatric Holistic Medicine, P.L.C.
Notice of Privacy Practices
As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 [HIPPA]
Effective Date of this Notice: April 14, 2003

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 (also called protected health information, or PHI). 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 legal duties and the privacy practices that we maintain in our practice concerning your PHI. 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 PHI
- Our obligations concerning the use and disclosures of your PHI
- Your privacy rights in your PHI

The terms of this notice apply to all records containing your PHI 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 of 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 have a copy of our current Notice in our office, and you may request a copy of our most current Notice at anytime.

B. If you have questions about this Notice, please contact: Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663.

C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI.

1. **Treatment.** Our practice may use your PHI 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 PHI in order to write prescriptions for you, or we might disclose your PHI 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 PHI in order to treat you or to assist others in your treatment. Additionally we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your PHI 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 PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI 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 PHI 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 PHI 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 PHI to other health care providers and entities to assist in their health care operations.
4. **Appointment reminders**. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health related benefits or services that may be of interest to you.
7. **Release of information to family/friends.** Our practice may release your PHI 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 the child's information.
8. **Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosures of your PHI 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 PHI to public health authorities that are authorized by law to collect information for the purpose of:
    a. Maintaining vital records, such as births and deaths
    b. Reporting child abuse or neglect
    c. Preventing or controlling disease, injury, or disability
    d. Notifying a person regarding potential exposure to a communicable disease, or potential risk for spreading or contracting a disease or condition
    e. Reporting reactions to drugs or problems with products or devices
    f. Notifying individuals of a product or device they may be using that has been recalled
    g. 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.
    h. 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 PHI 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 or disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI 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 your PHI if asked to do so by a law enforcement official:
    a. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    b. Concerning a death we believe has resulted from criminal conduct
    c. Regarding criminal conduct at our offices
    d. In response to a warrant, summons, court order, subpoena, or similar legal process
    e. To identify/locate a suspect, material witness, fugitive, or missing person
    f. 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)
5. **Deceased patients.** Our practice may release your PHI 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.
6. **Organ and tissue donation.** Our practice may release your PHI 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.
7. **Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:
    a. The use or disclosure involves no more than a minimal risk to your privacy based on the following (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii)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 (iii)adequate written assurances that the PHI 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;
    b. The research could not practicably be conducted without the waiver;
    c. The research could not practicably be conducted without access to and use of the PHI.
8. **Serious threats to health or safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others. 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 PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates**. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' compensation.** Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI 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 Compliance Officer, Pediatric Holistic Medicine, PLC, 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663, 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 PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI 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 PHI, you must make your request in writing to Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663. Your request must describe in 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 PHI that may be used to make decision about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663 in order to inspect and/or obtain a copy of your PHI. 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 information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663. 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 PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information

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 PHI for purposes not related to treatment, payment or operations. Use of your PHI 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 Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six 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 Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663.
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 Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663. 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 PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI 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 of our health information privacy policies, please contact Compliance Officer, Pediatric Holistic Medicine, P.L.C., 2350 Washtenaw Ave., Suite 24, Ann Arbor, MI 48104; 734-224-9663.