



# New Patient Forms

Please fill out completely and return to Dr Miles office.



Dear Patient,

Thank you for the opportunity to work with you. We utilize an integrative medical approach to health care that provides an array of treatment options. However, more importantly, I believe integrative medicine offers a distinctly different way of thinking about health.

The first office visit is where we gather the largest amount of information. Accordingly, this visit can last 1 to 1 1/2 hours. ***Please arrive 10 minutes prior to your scheduled appointment time.*** The New Patient Information Form is the start of our comprehensive discussion to learn about you. This form is somewhat long, but I appreciate your time to thoughtfully answer these questions. I kindly request that this form be filled out in its entirety prior to your appointment time, so that I can maximize my time spent with you.

Please inform my staff if any information included in this paperwork changes so we can keep your record updated. We will have you complete a medical release before your initial appointment so that we have a record of the people that you would disclose your medical information if needed. You can change this information if you decide to do so later. Please ask my staff if this needs to be done.

Thank you again for your interest in working with me. I look forward to meeting you.

**PLEASE DO NOT EMAIL THIS FORM TO US! This is not a secure way to send sensitive information to our office. This information can be faxed, mailed or dropped off at our office during office hours.**

Sincerely,

Laura Miles, MD

**912 NW 139<sup>th</sup> Street Parkway  
Edmond, OK 73013**

**Ph# 405-608-4447  
Fax # 405-286-1261**



# PATIENT INFORMATION SHEET

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
First Middle Last MM / DD / YYYY

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Preference? \_\_\_\_\_

SSN#: \_\_\_\_\_ Sex:  Male  Female Marital Status:  Single  Married  
 Divorced  Widowed

I authorize Dr. Miles and staff to email me at the following email address: \_\_\_\_\_

I do not want my labwork encrypted when e-mailed to me \_\_\_\_\_ (please initial if this applies)

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

I have no insurance

Primary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_  
First Last

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Contact #: \_\_\_\_\_

*(If policy holder is NOT the same as the patient, please provide the following information (for child or spouse):*

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_  
MM/ DD / YYYY

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_  
First Last

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Contact #: \_\_\_\_\_

*(If policy holder is NOT the same as the patient, please provide the following information (for child or spouse):*

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_  
MM/ DD / YYYY

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

**PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT**

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
First Last

Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

How did you hear about us/Referral? \_\_\_\_\_

CONTACT

EMPLOYER/INSURANCE INFORMATION

EMERGENCY CONTACT



Please initial beside each agreement:

AGREEMENT

\_\_\_\_\_ **Financial agreement:** I understand Dr. Miles fees are payable at the time of service. Dr. Miles is an out-of-network provider for all insurance companies and does not accept or file insurance claims. I also understand that if I am Medicare, Medicaid or Tricare eligible that by initialing I acknowledge that I cannot request reimbursement for service by Dr. Miles from those entities.

\_\_\_\_\_ **Exam agreement:** By initialing, I understand the philosophy of Dr. Miles is to work together with my current medical providers. Dr. Miles is an anti-aging and regenerative medicine specialist and does only preventative care medicine. She is not a primary care physician, internist, ob/gyn, endocrinologist, gastroenterologist or psychiatrist therefore it is important I maintain continued treatment by my current physicians. Dr. Miles does not address or treat acute conditions (i.e.: colds, flu, sinus problems, urinary tract infection, chest pain, etc.) I will always have to consult my primary care physician for any routine or emergent health concerns.

\_\_\_\_\_ **Privacy Policy:** By initialing, I acknowledge that I have received a copy and reviewed Vitruvia’s Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended notice of Privacy Practices at each appointment.

\_\_\_\_\_ **Cancellation Policy:** By initialing, I acknowledge that I have read, understand and agree to Dr. Miles 48 hour cancellation policy.

Our staff devotes specialized attention to all of our appointments, therefore we appreciate your efforts in keeping your appointments. In the unfortunate event of a cancellation, a 48 hour notice is required to cancel or reschedule. Should you decide not to keep the appointment for any reason without giving proper notice (outside of a medical emergency), you will be charged an \$85.00 cancellation fee.

Note: Due to the personalized services we provide, time is highly valued during your appointment. If you arrive more than 10 minutes late for your appointment, your appointment may be rescheduled and you will be charged our cancellation fee of \$85.00.

\_\_\_\_\_ **Medical Emergency Policy:** By initialing, I acknowledge that I have been informed of Dr. Miles office emergency policy. If I have a true medical emergency or serious medical concern I will call 911 immediately, not Dr. Miles. Messages left after regular office hours will be returned the next business day. It is my responsibility to seek appropriate medical attention in the meantime.

\_\_\_\_\_ **Health Savings Account:** I understand that I am responsible to inform Dr. Miles if I have a Health Savings Account (HSA). I also understand that if I have an HSA, that my insurance company in certain instances may submit any remaining balance of lab work ordered by Dr. Miles directly to my HSA for payment.

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I authorize the release of any medical or other information necessary to process any claims. By signing below, I agree that this information is correct and I have reviewed the above agreements.

SIGNATURES

SIGNATURE:  X  DATE: \_\_\_\_\_



# ADULT HEALTH QUESTIONNAIRE

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
First Middle Last MM / DD / YYYY

WHY YOU ARE HERE AND WHAT YOU NEED

Please list the reasons for this appointment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current medical problems being watched or requiring treatment \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Add'l Info: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list your current medical providers:

NAME	DATE	CARE PROVIDED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT



Prescription and supplement usage: **(PLEASE BRING ALL SUPPLEMENT/VITAMIN BOTTLES WITH YOU)**

Name of Medicine	Dose	# of Pills	Frequency	With Food/Without	
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
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_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATIONS

Allergies and Reaction:

**Are you Allergic/Sensitive to any:** Yes No **If YES,** please name the items and describe the reaction

Medications  Yes  No \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Foods  Yes  No \_\_\_\_\_

Plasters/tape/skin preparations  Yes  No \_\_\_\_\_  
 (e.g. iodine, chlorhexidine)

Latex  Yes  No \_\_\_\_\_

Other  Yes  No \_\_\_\_\_  
 \_\_\_\_\_

ALLERGIES & REACTIONS



REVIEW OF SYMPTOMS: Please mark the box for any **persistent symptoms** you have had in the past few months. Read through every section and check the symptoms that apply to you.

- SKIN:**
- Eczema/Psoriasis
  - Skin Rashes
  - Experiencing more breakouts/acne
  - Hives
  - Have had Botox before
- THYROID**
- Exhausted All Day
  - Cold Hands and Feet
  - Cold Intolerance
  - Difficulty Losing Weight
  - Losing Hair
  - Trouble Getting Up in the Morning
  - Puffy Face and Eyelids in the Morning
  - Eyebrows Thinning on the Outer Corners
  - Dry Skin
  - Have a goiter
- ADRENALS**
- Afternoon Fatigue
  - Frequently Sick
  - Feel Overcommitted in Your Daily Life
  - Increased Aggression
  - Crave Sugar
  - Crave Salt
  - Frequently Sick
  - Poor Endurance
  - Decreased Ability to Handle Stress
  - Consume 50% of your Calories after 5PM
- MUSCULOSKELETAL/NERVOUS:**
- Weakness
  - Tremors
  - Joint Pain/Arthritis
  - Swelling of Fingers/Ankles
  - Back Pain
  - Muscle Cramps
  - Numbness
  - Carpal Tunnel Syndrome
  - Fainting
  - Dizziness
- SLEEP**
- I have difficulty falling asleep. How many nights a week? \_\_\_\_\_
  - I wake up during the night. How many nights a week? \_\_\_\_\_
  - Wake Up in the Morning Not Rested
  - Go to Bed Late/Wake Up Late
  - Feet Feel Hot at Night
  - Very Affected by Jet Lag
  - I have difficulty going back to sleep if I Awaken During the Night
  - I go back to sleep easily if I wake up.
- GASTROINTESTINAL:**
- Chronic Sinusitis
  - Indigestion/Heartburn
  - Trouble Swallowing
  - Nausea/Vomiting
  - Change in Appetite
  - Bloating/Distension of Abdomen
  - Constipated Frequently
  - Diarrhea Frequently
  - Pass Mucus in Your Stool
  - Passing Blood in Stool
  - Frequent Urinary Tract Infections/Cystitis
- How many bowel movements do you have in a week? \_\_\_\_\_:
- Change in Bowel Habits
  - Intolerant to Greasy Foods
  - Pain Under Right Side of Ribcage
  - Gallbladder Disease
  - Liver Disease
  - Pancreatitis
- MOUTH/THROAT**
- Canker Sores
  - Cold Sores
  - Bad Breath
  - Loss of Taste
  - Gum Disease
  - Hoarseness
  - History of Root Canal
- GLUCOSE METABOLISM**
- Shakiness if You Go Too Long Without Eating
  - Sporadic Boosts and Drops of Energy Through the Day
  - Feel Tired 1-3 Hours After Eating
- COGNITIVE / FOCUS**
- Brain Fog
  - Decreased Mental Sharpness
  - Poor Short-Term Memory
  - Feel Blue or Depressed More than 10% of the Time
  - Have Taken Antidepressants
  - Feel Like Hurting Yourself If Yes, Have You Sought Treatment for this Condition? \_\_\_\_\_ Who is treating you? \_\_\_\_\_
  - Panic or Anxiety Attacks
  - Hard Time Focusing on your Work
  - Trouble Sitting for More Than 15 Minutes
- LIBIDO**
- Sexually Active?
  - Decreased Sex Drive/Interest?
  - Sexual Dysfunction or Have Any Sex Concerns?
  - Domestic or Sex Violence Concerns?
- MEN**
- Prostate Trouble
  - Erectile dysfunction
  - Difficulty getting an erection
  - Difficulty maintaining or not as hard as it used to be



Please check any symptoms you are **CURRENTLY** experiencing:

Symptom History:

SYMPTOM HISTORY

EYES

- Dry/Watery
 Double Vision

RESPIRATORY

- Asthma
 Cough
 Wheezing
 Shortness of Breath If Yes, Have You Sought Treatment for this Condition?
Who is treating you?
 Coughed Up Blood

GENITOURINARY

- Difficulty Urinating
 Incontinence
 Pain with Urination
 Increased Urgency
 Blood in Urine

CARDIOVASCULAR

- Chest Pain If Yes, Have You Sought Treatment for this Condition?
Who is treating you?
 Palpitations/Irregular Heartbeat
 High Blood Pressure

HISTORY OF:

- Prolonged/Frequent Antibiotics
 Frequent Ibuprofen/Tylenol
 Treatment of Mental Issues
 Drug/Alcohol Rehabilitation

WELLNESS

- I am a spiritual Person
 I have a Good Friend Network
 Major Stresses in the Past 3 Years

CANCER PATIENTS

- Type of Cancer:
 Stage of Cancer:
 Chemotherapy: If yes what Medications:
 Radiation
 Date of Completion of Chemo:
 Date of Completion of Radiation:
 Special testing (ie: BRCA)

Significant Past Medical History:

WOMENS HEALTH QUESTIONS

PERIODS: Age at first period:
Length of flow:
Start date of last period:
Age of last period (menopause) if applicable:

Check all that you are currently experiencing. If you are no longer having periods, please report how they were prior to menopause.

- Bleeding between periods
 Irregular periods
 Change in normal pattern

GYNECOLOGIC SYMPTOMS

Check all that apply and correlate with severity scale with 10 being most severe (1-10)

- Severe menstrual cramps
 Premenstrual irritability/mood swings
 Premenstrual/menstrual depression
 Premenstrual bloating/fluid retention
 Premenstrual breast tenderness
 Premenstrual headaches
 Hot flashes
 Night sweats
 Vaginal dryness/painful intercourse
 Premenstrual blues

BREAST - check all that you are currently experiencing:

- Monthly breast exams
 Fibrocystic breast disease
 Abnormal discharge from your breasts
 Breast implants

OVARIES/UTERUS-check all that apply:

- Ovarian cysts
 Endometriosis
 Uterine fibroids
 Abnormal pap smear Action:

REPRODUCTIVE HISTORY

How many pregnancies:
# Live births:
# Miscarriages:
# Terminations:
Your age of first birth:
Your age of last birth:

Check all that apply

- Breast fed How long (total of all infants)?
 Infertility treatments What kind?
 Took birth control pills How long?
 Date you discontinued?
 Currently using an IUD
 Had Depo-Provera

WOMENS HEALTH





What is your current method of birth control if applicable? \_\_\_\_\_

Please list all hormones you have taken and any problems with them (include estrogen, progesterone, testosterone, DHEA, & synthetic hormones): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WOMENS HEALTH

History of Hospitalization/Surgeries (start with the most recent and work backwards):

Procedures/Operations/Hospital Admissions	Year	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH HISTORY

Preventative Health History: List your most recent test date and results:

Procedures/Operations/Hospital Admissions	Date	Result
Bone Density Scan:	_____	_____
Colonoscopy:	_____	_____
Men – Prostate Exam:	_____	_____
Men – PSA Level:	_____	_____
Women – PAP Smear:	_____	_____
Women – Mammogram:	_____	_____
Cholesterol Level:	_____	_____
Calcium Heart Scan:	_____	_____



Substance Usage History

**Tobacco Use**

Smoke cigarettes:  Never  No  Yes  
(If you never smoked please go to alcohol use question now)

Year Stopped: \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_  
Approximately how many packs a day did you smoke? \_\_\_\_\_  
Current smoker: Packs/day: \_\_\_\_\_ # of years: \_\_\_\_\_  
Other tobacco:  Pipe  Cigar  Snuff  Chew

**Alcohol Use**

Do you drink alcohol?  No  Yes Alcohol Problem?  No  Yes  
# of drinks/day: \_\_\_\_\_ # of drinks/week: \_\_\_\_\_  
 Beer  Wine  Liquor

**Drug Use**

Do you use marijuana or recreational drugs?  No  Yes  
Have you ever used needles to inject drugs?  No  Yes

SUBSTANCE USAGE

List exercise types you do regularly:

WELLNESS

	1-2x per week	2-3x per week	3-5x per week
Run	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bike	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pilates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yoga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____		

Additional exercise: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Diet Diary

Please tell us what your average daily diet looks like:

DIET

Average wake up time: \_\_\_\_\_

Time of breakfast: \_\_\_\_\_

Typical breakfast meal: \_\_\_\_\_

Time of morning snack: \_\_\_\_\_

Typical snack:: \_\_\_\_\_

Time of lunch: \_\_\_\_\_

Typical lunch: \_\_\_\_\_

Time of afternoon snack: \_\_\_\_\_

Typical snack: \_\_\_\_\_

Time of dinner: \_\_\_\_\_

Typical dinner: \_\_\_\_\_

Time of after-dinner snack: \_\_\_\_\_

Typical snack: \_\_\_\_\_

Average bedtime: \_\_\_\_\_

Family History –

Check if you are adopted:

FAMILY HISTORY

	Age If Living	Age At Death	Present Condition or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers: # _____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters: # _____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children: # _____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____





## Dr. Laura Miles PRIVACY POLICY

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided, and for administration and operational purposes. The medical record is the property of this medical practice. If you have any questions about this notice, please contact: Dulcey Ruark, Privacy Officer for Dr. Miles/Vitruvia at (405) 608-4447.

#### **HOW THIS MEDICAL PRACTICE MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION**

**For Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. We may share your medical information with a pharmacist who needs it to dispense a prescription to you or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

**For Payment.** We use and disclose medical information about you to obtain payment for the services you receive. For example, a bill may be sent to you and/or to a third-party payor, such as an insurance company or health plan.

**For Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may use and disclose medical information about you to get your health plan to authorize services or referrals. We may also share your medical information with our business associates that perform administrative services for us. We have a written contract with each business associate that contains terms requiring them to protect the confidentiality of your medical information.

**Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

**Sign-in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

**Notification and Communication with Family.** We may disclose your medical information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition, or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved in with your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose medical information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable and unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

**Required by Law.** We may use and disclose medical information about you as required by law. For example, we may disclose information in the course of certain events or for the following purposes:

- To report information related to victims of abuse, neglect, or domestic violence;
- To assist law enforcement officials in their law enforcement duties;
- To respond to judicial and administrative proceedings or, in the course of judicial proceedings, if you have waived your rights to confidentiality under OK law; and,
- To help health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by federal and OK law.

**Public Health and Safety.** Your medical information may be used or disclosed for public health activities such as assisting public health authorities or legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. Your medical information may be disclosed to appropriate persons in order to prevent or lessen a serious and imminent threat to the health and safety of a particular person or the general public.

**Specialized Government Functions.** We may disclose your medical information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

**Coroners/Funeral Directors.** We may disclose your medical information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Workers' Compensation.** Your medical information may be used or disclosed as necessary in order to comply with laws and regulations related to workers' compensation.

**Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your medical information will become the property of the new owner, although you will maintain the right to request that copies of your medical information be transferred to another physician or medical practice.

**Marketing.** We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information for marketing purposes without your written authorization.



**Fundraising.** We do not participate in fundraising. If this policy changes, you will be given the option to opt out of receiving fundraising materials.

By OK law, we are required to notify you . . . **that your medical information used or disclosed as described in this Notice of Privacy Practices may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Deficiency Syndrome (AIDS).**

**WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR MEDICAL INFORMATION**

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose medical information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your medical information for another purpose, you may revoke your authorization in writing at any time.

**YOUR MEDICAL INFORMATION RIGHTS**

You have the right to:

- A paper copy of this Notice of Privacy Practices.
- Request restrictions on certain uses and disclosures of your medical information by written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.
- Request that you receive medical information in a specific way or at a specific location. For example, you may ask that we send you information at your work address. We will comply with all reasonable requests submitted.
- Obtain a copy of your medical information, with limited exceptions. A reasonable fee may be charged for making copies. Under current Oklahoma law, a fee of \$1.00 for the first page and \$0.50 per subsequent page is allowed and \$5.00 per film. We may also charge postage if the copies are to be mailed. If we deny your request for copies, you will be informed of your rights to appeal our decision.
- Request that we amend your medical information that you believe is incorrect or incomplete. Your requests to amend must be in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your medical information and will provide you with information about this practice's denial and how you can disagree with the denial. You also have the right to request that we add to your record a statement of up to two hundred fifty (250) words concerning any statement or item you believe to be incomplete or incorrect.
- Receive an accounting of disclosures made of your medical information by this medical practice unless the disclosures were for purposes of treatment, payment, health care operations, certain government functions, or pursuant to your written authorization. You have the right to revoke your authorization to use or disclose medical information except to the extent that this use or disclosure has already occurred.
- You can restrict personal health information regarding your treatment to your health insurance. You have the right to limit disclosures if you have already paid for the relevant care. Please submit any restrictions in writing to our office.

**IF YOU WOULD LIKE TO HAVE A MORE DETAILED EXPLANATION OF THESE RIGHTS OR IF YOU WOULD LIKE TO EXERCISE ONE OR MORE OF THESE RIGHTS, CONTACT OUR PRIVACY OFFICER LISTED ON THE FIRST PAGE OF THIS NOTICE OF PRIVACY PRACTICES.**

**OBLIGATIONS OF THIS MEDICAL PRACTICE**

We are required to maintain the privacy of your confidential medical information, provide you with this notice of our legal duties and privacy practices with respect to your medical information, abide by the terms of this notice, notify you if we are unable to agree with a requested restriction on how your information is used or disclosed, accommodate reasonable requests you make to communicate medical information by alternative means or alternative locations and obtain your written authorization to use or disclose your medical information for reasons other than those listed above and permitted under law. We are required to notify you in the event of a breach in unsecured personal health information. We reserve the right to change or amend this Notice of Privacy Practices at any time in the future. After an amendment is made, the revised Notice of Privacy Practices will apply to all medical information that we maintain. A copy of any Revised Notice of Privacy Practices will be made available to you at each appointment.

**COMPLAINTS**

Complaints about this Notice of Privacy Practices or how this medical practice handles your medical information should be directed to:

**Dr. Laura Miles**  
**912 NW 139<sup>th</sup> Street Parkway**  
**Edmond, OK 73013**  
**(405) 608-4447**

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

The Department of Health and Human Services  
 Office of Civil Rights  
 Herbert H. Humphrey Building, Room 509F  
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