STARK MEDICAL SPECIALTIES, INC.
2458 LINCOLN WAY EAST, MASSILLON, OH 44646
PHONE: (330) 837-1111 FAX: (330) 832-1341

APPT DATE/TIME: _____ DOCTOR:_____ HOW DID YOU HEAR ABOUT US?_____

FIRST NAME_____ MI_____ LAST_____ SS#_____

ADDRESS_____ CTY/STATE:_____ZIP_____PHONE (_____)_____

MARITAL STATUS: S M W D SEP DOB_____ AGE_____ SEX: M F

EMPLOYER_____ OCCUPATION_____

EMP. ADDRESS_____ CITY/STATE_____ ZIP_____ PHONE (____)_____

GUARANTOR (OR RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT) (PERSON RESPONSIBLE FOR PAYMENT)

GUARANTOR NAME_____ MI___ LAST_____ SS#_____

EMPLOYER_____ OCCUPATION_____

EMP. ADDRESS_____ CITY/STATE_____ ZIP_____ PHONE (_____)_____

INSURANCE INFORMATION:

PRIMARY INS_____ GROUP #_____ POLICY #_____

POLICY HOLDER'S NAME _____ ADDRESS_____

PHONE(_____)_____ POLICY HOLDER DOB_____ POLICY EFFECTIVE DATE_____

SECONDARY INS_____ GROUP#_____ POLICY#_____

POLICY HOLDER'S NAME _____ ADDRESS_____

PHONE(_____)_____ POLICY HOLDER DOB_____ POLICY EFFECTIVE DATE_____

MEDICAID___ CASE NAME_____ PROGRAM_____ RECPT#:_____ CASE#_____ EFF DATE____

INDUSTRIAL___ INJURED ON THE JOB: YES NO DATE OF INJURY_____ EMPLOYER_____ CLM #_____

ACCIDENT___ AUTO INVOLVED: YES NO DATE OF ACCIDENT_____ LOCATION_____

ARE YOU WORKING NOW: YES NO EMPLOYER_____ DATE OF LAST DAY WORKED_____

WHO REFERRED YOU_____ ADDRESS_____ PH#(_____)_____

NAME OF FAMILY DOCTOR_____ ADDRESS_____ PH#(_____)_____

LAST DOCTOR SEEN_____ ADDRESS_____ PH#(_____)_____

PATIENTS WHO CARRY HEALTH INSURANCE SHOULD REMEMBER THAT PROFESSIONAL SERVICES ARE RENDERED AND CHARGED TO THE PATIENT AND NOT THE INSURANCE COMPANY. EVEN THOUGH AN INSURANCE CLAIM IS FILED, YOU WILL RECEIVE A STATEMENT EACH MONTH IF YOUR ACCOUNT HAS A BALANCE DUE. THIS OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING YOUR INSURANCE CLAIM OR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT WITHIN THE LIMITS OF OUR CREDIT POLICY.

I CERTIFY THAT THE INFORMATION ON THIS FORM PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT (OR PARENT, IF CHILD IS UNDER 18 YEARS) X_____ DATE:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)
I HEREBY AUTHORIZE STARK MEDICAL SPECIALTIES, INC. TO FURNISH INFORMATION TO THE INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS.

Do you have a Living Will? _____Y _____N **Do you have a Durable Power of Attorney for Healthcare? _____Y _____N**

If no, would you like us to provide you with Living Will forms? _____Y _____N and/or DPOAH: _____Y _____N

SIGNATURE:_____ DATE:_____

Date_____

NEW PATIENT HISTORY

PLEASE fill out this form BEFORE YOUR APPOINTMENT. Your answers will help the staff plan and provide your care. Leve blank any parts you are unsure of, or do not wish to answer. We will review the form.
Any information we gather will be kept confidential PLEASE USE INK AND PRINT Thank You

First name:_____ **Middle Initial:**_____ **Last name:**_____

Age:_____ **Date of birth:**_____ **Sex: Male Female**

Reason for visit:_____

_____

_____

PAST MEDICAL HISTORY: Please check YES if you have any of the following and include the YEAR of diagnosis:

CONDITION	YES	YEAR	CONDITION	YES	YEAR
Heart Attack			GERD		
High Blood Pressure			Diverticulitis (osis)		
High Cholesterol			Gallstones		
Heart Disease			Liver Disease		
Heart Murmur			Kidney Disease		
Rheumatic Fever			Kidney Stones		
Scarlet Fever			Pyelonephritis		
Stroke			STDs		
TB (Tuberculosis)			Diabetes		
COPD			Cancer		
Asthma			Anemia		
Emphysema			HIV		
Pneumonia			Arthritis		
Thyroid Disease			Seizures		
IBS			Depression		
Stomach Ulcer			Anxiety		

If you had or have *cancer,* please tell us the type and stage, what physician(s) treated you and treatments you had:

_____

_____

_____

Do you have any problems with: Hearing_____ Vision_____

PHYSICIANS: Please tell us if you are currently seeing any other physicians and who your previous medical doctor was:

_____

_____

_____

HOSPITALIZATIONS: Have you ever been hospitalized? Please list the reason, approximate date and hospital:

_____

_____

_____

_____

PAST SURGERIES AND TESTING: Please check **YES** if you have had any of the following and include the **YEAR(s)**

Surgery	Yes	Year(s)	Test	Yes	Year(s)	Doctor
Mastectomy			Colonoscopy			
Hysterectomy			Stool Test			
Knee Surgery (R L)			Eye Exam			
Hip Replacement (R L)			Foot Exam			
Hernia Repair			Pap Test			
Back Surgery			Mammogram			
Gallbladder Surgery			PSA			
Appendectomy			Recta Exam			
Cataract Surgery (R L)						

ADDITIONAL TESTING: Please check **YES** if you have had the following and list the **YEAR(s)**, **LOCATION** and **DOCTOR**

Test /Procedure	Yes	Year(s)	Location	Doctor
Heart Catheterization				
Angioplasty/Stent				
Coronary Bypass				
EKG				
Stress Test				
Echocardiogram				
Chest X-Ray				
Holter Monitor				

TRANSFUSIONS: Have you ever received a blood transfusion: **Yes** **No**
If Yes, when and where:_____

ALLERGIES: List allergies and describe your reactions:

_____

_____

CURRENT MEDICATIONS: Please list all medications you currently take including prescriptions, over the counter, herbals and vitamins.

Name	Dose	How Often Taken	Reason For Taking	Prescribing Doctor

PHARMACY NAME:_____
ADDRESS: _____
PHONE:_____

EMPLOYMENT: Status: Full-Time Part-Time Retired Student Homemaker Unemployed
What is your job title?_____

Where do you work/go to school?_____)

Race_____ **Hand Dominance:** **Right** **Left** **Ambidextrous**
Ethnicity_____ **Religion**_____ **Church**_____
Preferred language_____ **Country of Birth**_____

SOCIAL HISTORY:
Marital Status: Are you (please circle) **Single** **Married** **Divorced** **Widowed** **Separated**
Children: Do you have any children? **Yes** **No** How many?_____ Boys_____ Girls_____
Pets: Do you have any pets? **Yes** **No** How many?_____
What kind of pets do you have?_____

OCCUPATIONAL EXPOSURE: Have you ever been exposed to asbestos, glass, chemicals, or fumes? **Yes** **No**
MILITARY HISTORY: Are you currently or have you served in the miliary? **Yes** **No**
What branch of the military?_____
How many years? From what year_____ to what year_____
Where were you **stationed?**_____
RECREATIONAL/STREET DRUGS/STEROID USE: Have your ever used recreational, street drugs or illegal steroids?
Yes, Currently **Yes,** In The Past **Never**
If yes, what did you use?_____

TOBACCO-CIGARETTES: **Age Started**_____ **Age Stopped**_____ **Method used to stop**_____
Do you smoke: **Yes** **No** Have you ever smoked? **Yes** **No** If yes, when did you quit?_____
How many packs of cigarettes/cigars do you smoke per day?_____
How long have you been smoking?_____ *or* how long did you smoke before quitting?_____
Would you like to quit? **Yes** **No** Have you tried to quit before? **Yes** **No**

CHEWING TOBACCO: **Age Started**_____ **Age Stopped**_____ **Method used to stop**_____
Do you chew tobacco? **Yes** **No** Have you ever chewed tobacco? **Yes** **No**
If yes, when did you quit?_____ How many cans do you use per day?_____
How long have you been chewing tobacco?_____ or how long did you chew before quitting?_____
Would you like to quit? **Yes** **No** Have you tired to quit before? **Yes** **No**

VAPE USE: **Do You Vape? Yes** **No** **Age Started**_____ **Age Stopped**_____
Do You Vape Without Nicotine? Yes **No**

ALCOHOL USE: Do you drink alcoholic beverages regularly (at lest one drink per month)?
Yes, Currently **No** **Former**
If you answered *"yes"* to any of the above questions, please complete the table below.

TYPE OF ALCOHOL	How Much	How Often	Last Drink
Beer			
Wine			
Liquor			

Have you ever quit drinking? **Yes** **No** If yes, how old were you when you quit?_____

EXERCISE: Do you exercise regularly? **Yes** **No** How many times per week?_____
What type of exercise? _____

DIET: Do you follow a special diet? (i.e. diabetic, gluten free, low cholesterol) **Yes** **No**
If yes, what type and why?_____

CAFFEINE: **Type:**_____ **Amount Per Day** _____

LIVING WILL/DURABLE POWER OF ATTORNEY FOR HEALTH CARE:

If you have one or both of these, please bring them in so we can keep them on file.

Do you have a Living Will? **Yes** **No** Durable Power of Attorney for Health Care? **Yes** **No**

If yes, please list the contact's name and phone number:_____

IMMUNIZATIONS: Please check if you have or have not had the following vaccines and the **MONTH AND YEAR** it was given.

Vaccine	Yes	No	Month/Year
Flu Shot			
Covid			
Pneumovax			
Tetanus			
Zostavax			
Hepatitis A			
Hepatitis B			
Gardasil (series)			
Shingrix			
Prevnar 13			
HPV			

FALL RISK: **Do you use any of the following? Walker** **Cane** **Wheelchair**

Falls In The Last Year? YES NO

Number Of Falls _____

Did the falls result in injury? YES NO **If YES please explain:** _____

FAMILY HISTORY: Do any of your relatives have the following? If yes, please let us know who.
(Mother, Father, Brothers, Sisters, Maternal Grandparents, Paternal Grandparents, Children)

Condition	Yes	Who	Condition	Yes	Who
Diabetes			Heart Attack		
High Cholesterol			Stroke		
Seizures			Arthritis		
Blood Disorders			Kidney Disease		
Liver Disease			Cancer		
Heart Disease			Alcohol/Drug Abuse		
High Blood Pressure			Depression/Anxiety		

If anyone in your family has died, how old were they when diagnosed; what was their age at death and what was the cause of death?

_____

_____

_____

PAIN ASSESSMENT:

Do you have pain on a daily basis? YES NO

Please rate your pain on the scale below with 10 being intolerable pain.

0 1 2 3 4 5 6 7 8 9 10

Other:_____

_____

_____

REVIEW OF SYSTEMS: Are you currently experiencing any of these symptoms? Please circle **YES or NO**

CONSTITUTIONAL		
Recent weight change	Yes	No
Loss of appetite	Yes	No
Fatigue	Yes	No
Chills	Yes	No
Sweats/Hot Flashes	Yes	No

Skin		
Rashes	Yes	No
Itching	Yes	No
Abnormal Moles	Yes	No

HEAD/EYES/EARS/NOSE/THROAT/NECK		
Chronic Headaches	Yes	No
Migraines	Yes	No
Eye Pain	Yes	No
Vision Changes	Yes	No
Ear Pain	Yes	No
Ear Drainage	Yes	No
Hearing Loss	Yes	No
Ringing In The Ears	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No
Nasal Drainage	Yes	No
Recurrent Throat Infections	Yes	No
Hoarseness	Yes	No
Neck Stiffness	Yes	No
Neck Tenderness	Yes	No
Lymph Nodes	Yes	No

URINARY		
Burning	Yes	No
Blood In Urine	Yes	No
Urgency	Yes	No
Frequent Urination	Yes	No
Nighttime Urination	Yes	No
Incontinence	Yes	No
Frequent Urinary Infections	Yes	No

FEMALES		
Vaginal Discharge	Yes	No
Abnormal menses	Yes	No
Menopause	Yes	No
Postmenopausal Bleeding	Yes	No
Age of 1st Period _____	Yes	No
Last Period ____/____/_____	Yes	No
# of pregnancies _____	Yes	No
# of births_____	Yes	No
# of abortions_____	Yes	No
Breast Mass	Yes	No

HEART		
Chest Pain	Yes	No
Palpitations	Yes	No
Shortness Of Breath At Rest	Yes	No
Shortness Of Breath With Activity	Yes	No
Shortness Of Breath With Laying	Yes	No
Swelling	Yes	No
Calf Pain With Walking	Yes	No

LUNGS		
Chronic Cough	Yes	No
Sputum Production	Yes	No
Cough Up Blood	Yes	No
Snoring	Yes	No

GASTROINTESTINAL		
Heartburn	Yes	No
Problems Swallowing	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Abdominal Pain	Yes	No
Blood in bowels	Yes	No
Blood in vomit	Yes	No
Jaundice Yellowing Of The Skin	Yes	No
Hemorrhoids	Yes	No
Changes in Bowels	Yes	No

HEMATOLOGY/ONCOLOGY		
Bruise Easily	Yes	No
Prolonged Bleeding	Yes	No

MUSCULOSKELETAL		
Joint Pain	Yes	No
Muscle Pain	Yes	No
Arthritis Pain	Yes	No
Numbness/Tingling	Yes	No
Specific Muscle Weakness	Yes	No
Red, Hot, Swollen Joints	Yes	No

NEUROLOGICAL/PSYCHOLOGICAL		
Depression	Yes	No
Anxiety	Yes	No
Passing Out	Yes	No
Dizziness	Yes	No
Seizures	Yes	No
Tremors	Yes	No
Insomnia	Yes	No
Poor Memory	Yes	No

REVIEW OF SYSTEMS: Are you currently experiencing any of these symptoms? Please circle **YES or NO**
Continued:

ENDOCRINE		
Excessive Thirst	Yes	No
Excessive Hunger	Yes	No
Excessive Urination	Yes	No
Intolerance to Heat	Yes	No
Intolerance to Cold	Yes	No
Changes in Nails	Yes	No
Hair Loss	Yes	No

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices.

I acknowledge that I have received this Notice of Privacy Practices and that I understand that if I have any questions regarding this Notice, I may contract the Privacy Officer of Stark Medical Specialties, Inc.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Signature of Parent/Guardian/Power of Attorney (specify which):

_____ Date: _____

For Office Use Only:

Signed Acknowledgement of Receipt on _____ Initials_____

Notice of Privacy Practices sent/delivered on _____ Initials_____

Patient Refused or Failed to Acknowledge Receipt on_____ Initials _____

Stark Medical Specialties, Inc.
2458 Lincoln Way E
Massillon, OH 44646
P: (330) 837-1111
F: (330) 832-1341

Authorization For Release of Protected Health Information

I,_____, ____/____/____, ____/____/____ authorize
(print patient's name) (birthdate) (Social Security No.)
my medical information be released to the following:

TO: (Facility Name) Stark Medical Specialties, Inc. From: (Facility Name) _____

Street Address 2458 Lincoln Way E _____

City, State, Zip) Massillon, OH 44646 _____

MAIL _____ FAX #: (330) 832-1341 PICK UP ON _____

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PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

_____ 1. I authorize all information in my medical record from (date) _____ to (date)_____ to be disclosed according to the terms of this Authorization.

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INITIAL ONE OF THE FOLLOWING:

_____ I consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

_____ I do not consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any Condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome).

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FOR THE PURPOSE OF:

_____ Continued Care: _____Personal Use Other:_____

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1. This authorization shall be in full force and effect for (60) sixty days from the date of the signing, at which time this authorization shall expire.
2. My permission is extended only for the purpose as stated on this authorization and I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Stark Medical Specialties, Inc. at 2458 Lincoln Way E, Massillon, OH 44646. I understand that a revocation is not effective to the extent that Stark Medical Specialties has relied on the use or disclosure of the protected health information.
3. I understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical record as permitted by law. _____ (initial)
4. I understand that information used or disclosed pursuant to the authorization my be subject to redisclosure by the recipient and may no longer be protected by federal or state law. If Stark Medical Specialties is receiving the information, Stark Medical Specialties will only use or disclose the information as permitted by law or as authorized by you.
5. Stark Medical Specialties will not condition my treatment on whether I provide authorization for the requested use or disclosure.
6. I understand I have the right to refuse to sign this authorization. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under law.

_____ _____
(signature of patient or guardian) (relationship to patient) (date)

_____ _____
(address) (home phone number)

_____ _____
(city, state, zip) (work phone number)

REQUEST FOR ALTERNATIVE COMMUNICATIONS

You have the right to request Stark Medical Specialties communicate with you about your protected health information by alternative means or at alternative locations. The request must be made in writing by completing this form.

Stark Medical Specialties must comply with your request if it is administratively reasonable for Stark Medical Specialties to communicate with you in the manner you requested. Stark Medical Specialties will notify you in writing within thirty (30) days of receiving your request whether it will abide by your request. Stark Medical Specialties may condition your request by requiring information as to how payment will be handled and specification of an alternative address or manner contact.

If you have any questions regarding your rights or how to complete this form, please contact the Privacy Officer at (330) 837-1111.

Client Name: _____ SSN: ____-____-____ DOB: _____

Address: _____

Telephone number (s): Home: _____ Cell: _____ Work: _____

Please specify the manner in which you request Stark Medical Specialties to communicate with you regarding your protected health information:

_____ Phone Message ____ Fax#: _____ _____ Answering Machine

_____ Relative: _____ Telephone #: _____
Name

_____ Other: _____ Telephone #: _____
Name

_____ _____
Client/Representative Signature Date

_____
Representative's Relationship to Client

Please return this form by hand-delivering it to the Privacy Receptionist, or mailing it to the following address:

Stark Medical Specialties, Inc.
C/o Privacy Receptionist
2458 Lincoln Way East
Massillon, OH 44646-6114

Phone: (330) 837-1111 Fax: (330) 832-1341

Authorization For Release of Protected Health Information

NOTICE OF PRIVACY PRACTICES

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 are requested by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. Except when prohibited by Ohio or federal law, we may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR /164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure of the information relevant to that person's involvement in your healthcare or payment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy officer identified below. The revocation will not be effective to the extent we have already taken action in reliance of the authorization. Any disclosure will also be subject to Ohio and federal law governing sensitive information such as psychotherapy notes, sexually transmitted diseases, alcohol and substance abuse information, and mental health information, as applicable, and may require your written authorization. For example, most disclosures regarding the results of an HIV test, or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition require that individual's written authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information or treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service at the time of receipt of the item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances; e.g., if we determine that disclosure may result in harm to your or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons; e.g., if we did not create the record or if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have the right even if you have agreed to receive the Notice electronically.

5. Changes to This Notice. We reserve the right to change the terms of this Notice at any time and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliation against you for filing a complaint.

7. Contact Information. If you have questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer: Colleen King
Phone: (330) 837-1111 Address: 2458 Lincoln Way E, Massillon, OH 44646
Email: colleenk@starkmedical.net

Effective Date. This Notice is effective October 1, 2013