Welcome to Our Office

(Title) __Mr. __Mrs. __Ms. __Dr. **Please PRINT**

LEGAL Name **(Last)**_____ **, (First)**_____ **Mi**____ **Jr Sr**

Address_____ Suite_____ **City**_____

State_____ **ZIP**_____ **DOB**(Date of Birth)_____-_____-_____ **Sex: M F**

Home Phone (_____**)** _____ **Work Phone (**_____**)** _____

Occupation_____ **CELL Phone (**_____**)** _____

Race ☐**White** ☐**Asian** ☐_____ ☐**Decline** answer **Preferred Language** ☐**English** ☐_____ **Ethnicity** ☐**Hispanic** ☐**Non Hispanic** ☐**Decline** answer

- **Who is responsible for this account ?** ☐**Self** ☐ **Other**

  If Other, identify Relationship ☐Parent ☐Spouse ☐Power of Attorney ☐Guardian ☐Other_____

  Identify **Name** of responsible party (If not self) _____

- **Do you have Vision Insurance?** No **Yes (Circle Type)** EyeMed Gilsbar Great West Spectera Avesis Other_____
- **What type of Medical Insurance do you have ?** ☐**BCBS** ☐**Medicare** ☐ **Aetna** ☐ **UHC** ☐Other_____

We Do Not Accept - VSP - Humana - PacifiCare - Cigna - Secure Horizons - GreatWest - Golden Rule – and/or other PPO/HMO Plans

Vision examinations for "Routine Eye Examinations" and glasses prescriptions Start at $90. Vision Insurance Plans (Such as Aetna, Avesis, EyeMed, Gilsbar, and Spectera) cannot be used for treatment of eye infections or eye problems. Vision Insurance Plans can be used only for prescribing vision corrections (Refractions). **Contact lens fitting/exams require addition fees** and **follow-up care** (range $60-200) ask for quotes.

Medical examinations and treatment of eye disease such as cataract, glaucoma, macular degeneration, diabetic retinopathy Start at $60 (range $60-150). Medical eye examinations require more time, documentation, and more professional judgment to identify the reason and the appropriate treatment.

Certification of Information

I certify that the identifying information, addresses, and telephone Information I have provided is correct and agree to inform the practice if such information changes or becomes outdated. HIPAA NOTICE OF PRIVACY PRACTICES (*INFORMATION RELEASE CONSENT)* – I, the patient, authorize any holder of medical/optical information to release information about me to, Dr. Kenneth O'Daniel & Associates, P.C. and I authorize Dr. Kenneth O'Daniel & Associates, P.C. to release medical/optical information about me to other health care professionals, attorneys, or insurance companies via mail or electronic transmission.

HIPAA - The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices,* the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (**1**) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (**2**) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (**3**) our submission of your health information to auditors hired by third-party payers and insurers; and (**4**) other aspects of payment described in our *Notice of Privacy Practices.* Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Dr. Kenneth O'Daniel & Associates, P.C. This document shall remain in effect until revoked by patient. Please note the AARP Website is incorrect "We DO NOT provide Discounts to AARP Members" Our office Opted out of this program.

Contact Lens Prescriptions are not released until after the initial fitting and follow-up care is complete. We accept Medicare assignment on a case-by-case basis. Not all Doctors in our office have a Medicare license. A prescription recheck is available at no charge for 30 days from the original date of the exam. However, fees will apply after 30 days. Discounts are only provided at the time of service and may not be combined with other promotions or discounts. Payment for services and contact lenses are expected at time of service. You will be charged **$25-$80 for a missed appointment** if not cancelled 24 hr in advance. A $25 Charge will be billed for checks returned for any reason. **Verbal abuse**, discourtesy, and or hostility directed to any staff member or doctor will result in Immediate Termination from our practice and no refund or compensation will be issued. **Many insurance plans Do Not cover** the full cost of the contact lens fees; therefore, you will be responsible for any uncovered costs.

- **Professional fees are NOT refundable**. **Dilation may cause** light sensitivity and your vision to be temporarily blurry up close (for 3-5 hrs).
- **I acknowledge that the Contact Lens Fitting & Contact Lenses are a Separate Billable Procedures and the fees are listed on the back of this form.**
- **Retinal Photography** is a recommended but **optional procedure** not covered by most insurance plans – the fee is $25
- A patient with a delinquent account will also assume all legal fees & additional costs associated with collection of their account plus late fees.
- A late fee of $10 and a finance charge of 2% per month will be added to any unpaid balance if not paid within 30 days of the incident date.
- **It is *ultimately* the patient's responsibility** to know their insurance benefits prior to being seen in our office. Member benefits are a contract between the patient and the insurance company. Having Insurance Verification Does Not guarantee payment benefits on your behalf, you the patient are responsible for payment if your insurance declines payment.

_____ x_____ _____

Printed Name if not Patient (or Power of Attorney) **Patient's Signature** (or Guardian if under 18 Yrs of age or Power of Attorney) **Date**

Dr. Kenneth O'Daniel & Associates, PC

CONTACT LENS FITTING FEES EXPLAINED

We want you to understand what is involved with a contact lens fitting. If you have any questions, please do not hesitate to ask. On the day of your examination, if needed and time permitting, an optometric technician will instruct you on insertion and removal of the lenses. If this is not possible, you will be given a return appointment to meet with one of the opticians for this instruction session. After receiving these instructions, you will wear the lenses for one to two weeks and return for a follow-up examination to evaluate the fit and prescription. If you are a previous wearer and no changes have been made to the fit, you will be free to purchase your prescribed lenses the day of the examination and will not need to go through the "trial" phase.

Below are the categories of Fitting Fees. Your fees will be determined by the physician, are **due at the time of the fitting and are non-refundable.** If you decided to "up-grade" to a different category (i.e. monovision to bifocals) after the initial visit, additional fees will be added.

- **Fitting Fees are as follows** *(fees subject to change):*
  (This re-validates your prescription for one year.) **$60 - $100 Typical Refitting fee or Annual Refit**
- **Contact Lens Fitting fees may vary** depending on the amount of time required & complexity of the fitting. Returning patients in Specialty Lenses may receive a discount on the refit depending on the complexity and the amount of time required. Difficult fits may be charged more than our normal fee if additional time & expertise is required.
- **Exam Fees and CL Fitting fees do NOT include the price of the contact lenses.**
- **Contact lenses are NOT included in the cost of the exam (**Contact lenses are priced in addition to the exam & fitting fees**).** You may purchase contacts from our office at a discounted fee or any retail optical.

Annual Vision Examination is additional to the Fitting Fees

Soft: or Annual Refit	
CL Fitting Daily Wear	$60
CL Fitting Extended Wear	$75
Specialty Soft Lenses: or Annual Refit	
Toric CL Fitting	$85
Multifocal CL Fitting	$90
Specialty Contact Lenses: or Annual Refit	
Spherical Gas Perm	$100
Gas Perm Toric	$150
Gas perm Bifocal/Multifocal	$175
Keratoconus	$200-250
Post corneal surgery	$200-250
Other corneal deformities	$200-250
Additional Fees:	
First-time wearing Contacts	Add $25
Monovision	Add $25

Fitting fees cover up to 2 months of follow-up care. **If seen after the initial two-month period or in excess of three visits, you will be charged a fee of $40.00.** You must have follow-up care in order to purchase contact lenses, unless otherwise authorized by the doctor.

The price of the contact lenses will vary depending on type and prescription.
Tinted cosmetic colored lenses cannot be returned, most other lenses may be returned or exchanged within 60 Days of the order date.
Disposable lenses or boxes must be Unopened and must be in original condition with NO MARKS on boxes.
Damaged or opened contact lens boxes cannot be returned. **Contacts must be paid for in full at the time of dispensing**.
Changes in the lenses may be made within the first two months if unopened.

You are entitled to a copy of your contact lens prescription once the examining doctor finalizes the prescription. Receiving a trial lens may NOT constitute a finalized prescription.

Contact lens prescriptions are valid for one year.
Professional fees and contact lens fitting fees and are non-refundable

I have read and understand the above information and agree to the terms set forth in this agreement. I also acknowledge that I have had all my questions answered. Signature of acknowledgement in on the reverse side.

Medical Case History

Patient **Name**:_____(last), _____(first) **Age**_____ **Date**:_____/_____/201____

Indicate what disease you have or are being treated for **Check "ALL" Appropriate Boxes**

Review of Systems

Constitutional ❑None
❑Weight Loss
❑Fever
❑Fatigue

Ears Nose Throat ❑None
❑Chest cold
❑Flu
❑Sinus

Cardiovascular ❑None
❑Heart disease
❑Cholesterol
❑Stroke
❑Hypertension

Respiratory ❑None
❑Asthma
❑Bronchitis
❑Emphysema

Gastrointestinal ❑None
❑Ulcer
❑Digestive
❑Colitis

Genitourinary ❑None
❑Urinary tract infection
❑Kidney problem
❑Std ❑Herpes

Musculoskeletal ❑None
❑Arthritis
❑Muscular dystrophy
❑Fibromyalgia

Integumentary ❑None
❑Acne Rosacea
❑Eczema
❑Psoriasis
❑Shingles in past

Neurological ❑None
❑MS
❑Epilepsy
❑Seizures ❑Myasthenia Gravis

Psychiatric ❑None
❑Depression
❑Panic Disorder

Endocrine ❑None
Diabetes ❑Type 1 ❑Type 2
❑Thyroid dysfunction

Blood Lymph ❑None
❑Leukemia
❑Anemia

Allergic/Immunologic ❑None
❑Seasonal allergies
❑Lupus ❑Cancer

1. **WOMEN** only – Are you **PREGNANT**? **Yes** No Are you **NURSING**? **Yes** No
2. **Are you ALLERGIC** to any **Medications**? ❑No ❑**Yes**, List_____
3. **Do you take** any Medications? ❑No ❑**Yes**,….If yes list drug or reason_____
_____
4. **Do you have** any of the following Diseases? ❑No ❑**Yes,…..**If yes circle or list disease STD Hepatitis HIV Syphilis Lyme disease
5. **List** any EYE or Major surgeries you have had. **RK**_____Year **Lasik**_____Year **Cataract** _____ Year Other_____
6. **List** any other major illness you have had or presently have_____
7. When was your LAST Eye Exam? _____Yr _____Months **When** was your LAST **Physical** Exam? _____Yr _____Months

Social History

1. Do you use **Tobacco** products? ❑No ❑**Yes** _____Years _____Packs/Day
2. Do you drink **Alcohol**? ❑No ❑**Yes** _____Drinks per Day
3. Do you use **Narcotics**? ❑No ❑**Yes** _____Type (ie Cocaine, morphine)

Family History and Ocular History

Do any family members have any of the following conditions? (If yes, list relationship to you). If unknown or none check this box ❑**None**

		Family Member			Family Member
❑ Blindness	❑Self		❑ Corneal problem	❑Self	
❑ Cataracts	❑Self		❑ Lazy eye	❑Self	
❑ Glaucoma	❑Self		❑ Diabetes		
❑ Macular Degeneration	❑Self		❑ Heart Disease		
❑ Retinal Detachment	❑Self		❑ Cancer		

Any Question left BLANK will be assumed to be Negative or Normal

I, the patient, acknowledge the above Medical History is accurate and complete

Note: Please note the AARP Website is incorrect "We DO NOT provide Discounts to AARP Members" Our office Opted out of this program

Patient Signature (or Guardian if under 18 yr old)_____

Please complete and sign the section below

Insurance Information

_____ _____ [ ]**Xm** [ ]**CL**Xm **Date**_____/_____/201___ **Time**_____Am Pm

Vision Insurance Carrier **Employer**

_____ _____/_____/_____ _____

Patient **Last Name, First** **Patient Date of Birth** **Patient's Member ID Number**

_____ [ ]Self [ ]Spouse [ ]Child _____

Primary Insured Name (if not patient) **Relationship** **Group** /Plan number

_____ **[ ]Male [ ]Female** _____ **[ ]Full Time [ ]Part Time**

Primary's Date of Birth **Sex** of **Primary** **Primary's Social Security Number** If patient is a student indicate

Choose **How** Do You wish to use your benefits? Towards **[ ]Glasses** or **[ ]Contacts**

If you select glasses you will be responsible to pay for the Contact lens fitting and Contacts out of pocket

I hereby authorize Dr. Kenneth O'Daniel & Associates to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from my vision care insurer be made directly to the vision care provider, Dr. Kenneth O'Daniel & Associates. Authorization of vision insurance benefits are transmitted via internet as dictated and controlled by your insurance provider -This authorization allows Dr. O'Daniel & Associates to lookup your insurance benefits and submit your insurance benefits online (via internet). Unpaid claims are sent to collection if not paid promptly. I authorize any outstanding balance to be charged to my credit card on file.

Note: Ameriben & OptumHealth Vision (Contact lens exam & Contacts), and/or MMSI Mail Handlers Insurance may not pay for routine eye care and they DO NOT guarantee accuracy with benefit authorization. Therefore, the member will be responsible for any balance due after 60 days.

Informed Consent - I further authorize this vision care provider to release my vision care insurer and its agents any information related to this or any related claim. I certify that the above information I have reported about my coverage is correct.

- **I agree to assume responsibility of full payment pending any remaining balance that is not covered by insurance.**
- **I understand that after 60 days any remaining balance becomes the responsibility of the patient and the primary cardholder.**
- **I agree to pay any unpaid balance within 60 days.**
- **It is *ultimately* the patient's responsible to know their insurance benefits prior to being seen in our office. Member benefits are a contract between the patient and the insurance company.**
- **Having Insurance Verification Does Not guarantee payment benefits on your behalf, you the patient are responsible for payment after 60 days if your insurance declines payment.**

SIGN → X_____ DATE →

Member's Signature ***Must be over 18 years of age** Date

For Office Staff Only - DO NOT Write below this area

Benefit Details

CL Package		Exam co-pay	
Standard Fit		CL fit co-pay	
Premium Fit discount		CL Pkg (if using)	
Authorization		Retinal Photos	
		TOTAL TO COLLECT from patient	
		CREDIT towards contacts	

Date Submitted _____ [ ]Xm [ ]ClXM pkg [ ]Online [ ]Hicfa

Date Re-submitted _____

Claim # _____ Ref#_____ Spoke with_____ on Date_____

Notes:_____

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as EyeMed or Avesis)
2. Medical insurance (such as Blue Cross/Blue Shield and Medicare).

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

By signing the front of the Insurance Information sheet you agree that you have read and agree with these policies.

Please provide us with **a Photo ID of both** your **Vision & Medical insurance cards**.

Dr. Kenneth O'Daniel & Associates, P.C.
7014 E Camelback Rd #2140
Scottsdale AZ 85251
Telephone(480) 945-3937 Fax (480) 990-1100

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event, we make a material change in our privacy practices; we will change this Notice and provide it to you.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the top of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to an optician, ophthalmologist or other healthcare provider providing treatment to you for: a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; (c) the referral of a patient for health care from one health care provider to another; or (d) recall information.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

To You, Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Decedents. Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. We may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Medical records: Patients can now ask for copies of their electronic medical information in electronic format for offices which use electronic medical records. Also, with both paper and electronic record requests, the office has only 30 days to produce the information.

Cash paying patients: When patients pay for services personally and in full, they can require that the office not share information about the treatment with their health plans.

Immunization records: The office can give immunization information to a school if the school is required by law to have it and if the parent or guardian gives written permission.

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also contact you to conduct our own surveys about the quality of the products and services we provide.

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities, for the last 6 years, but not for disclosure made prior to Aprill4, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact Dr. Kenneth O'Daniel.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon written request.