**Tallmadge Physical Therapy & SportsCare**
**85 Community Road Suite D**
**Tallmadge, Ohio 44278**
330-630-0630
Fax 330-630-9799

# INFORMATION FOR NEW PATIENTS

Your initial evaluation should take approximately an hour to an hour and a half.

Filling out all your paperwork prior to your first appointment will speed up your check-in process. If you have not filled out your paperwork in advance, please arrive 15 minutes early for your first appointment to complete the necessary forms.

Please bring to your first appointment:

- Your prescription for physical therapy
- Your insurance card
- Your completed paperwork
- The last two pages of paperwork is our Privacy Notice. You do not need to print it.

Wear loose, comfortable clothing and athletic shoes.

Please feel free to call our office at 330-630-0630 with any questions you many have.

# DIRECTIONS

Our office is located across from the Tallmadge Library and Tallmadge Community Center and adjacent to Pioneer Physicians/Northeast Family Health Care.

**Directions from Tallmadge Circle:**

From Tallmadge Circle, take East Avenue to Community Road.
Turn left onto Community Road.
Turn left into the first driveway and then turn right into the first parking lot.

# Tallmadge Physical Therapy & SportsCare

**85 Community Road Suite D**
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Appt Date: _____ Therapist: _____ Account #: _____

| | | | |
|---|---|---|---|
| Patient Name: | | Social Security #: | |
| Address: | | _____Male | _____Female |
| City: | State: | Zip: | |
| Phone: | Date of Birth: | Circle: Single | Married Divorced Widow Other |
| Responsible Person: | | Relationship to Patient: | |
| Resp. Person Address: | | City: State: | Zip: |
| Emergency Contact: | Phone: | Patient's E-Mail: No Billing, Informational Only | |

| | | | |
|---|---|---|---|
| Patient Employer/School Name: | | Phone: | |
| Address: | City: | State: | Zip: |

| | |
|---|---|
| Referring Physician: | Primary Care: |
| Diagnosis: | Script Date: |

Is Patient's Condition Related to: Auto___ Employment___ Date on Onset/ Injury Date: _____ / _____ / _____

Has patient had chiropractic, physical, occupational or speech therapy **this year**? Yes___ No___
**If Yes,** Date(s) Seen _____ Where seen ? _____

**MEDICARE PATIENTS:** Have you had any In-Home / Home Health Care **this year**? Yes___ No___
**If Yes,** Date(s) Seen _____ By Whom / What Agency ? _____

How did you become aware of our services? Physician___ Patient___ Ad___ Radio___ Website___ School___ Other___

## Primary Insurance: Health____ Auto____ Workers' Comp____ Other_____

| | | | |
|---|---|---|---|
| Name of Insurance: | | Phone#: | |
| Address: | City: | State: | Zip: |
| Policy Holder: | SS#: | Date of Birth: | |
| Policy / ID#: | Group #: | Employer: | |

## Secondary Insurance: Health____ Auto____ Workers' Comp____ Other_____

| | | | |
|---|---|---|---|
| Name of Insurance: | | Phone#: | |
| Address: | City: | State: | Zip: |
| Policy Holder: | SS#: | Date of Birth: | |
| Policy / ID#: | Group #: | Employer: | |

# Tallmadge Physical Therapy & SportsCare

**85 Community Road Suite D • Tallmadge, Ohio 44278 • 330-630-0630**

## ABOUT FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Office co-payments are due at the time services are rendered. We accept cash, checks, credit and debit cards. We will gladly discuss your proposed treatment plan and answer any questions relating to your insurance.

Please understand that:

1. Your insurance is a contract between you, your employer and insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to a maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "UCR". "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to know your own contract.
4. If your workers' compensation claim is denied you are ultimately responsible for payment of services.
5. If you are self-pay, a payment on your balance is required at the time of each visit. Your payment will be _____.

While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If your account is turned over to a collection agency, you will be responsible for an initial fee of 38% plus any other associated fees for debt collection.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

### CONSENT FOR TREATMENT

I consent to the examination, tests, and treatments, which may be done by my therapists and therapy staff during my course of therapy. I understand I have the right to be informed about my treatment.

### RELEASE OF RESPONSIBILITY

I understand that Physical Therapy and SportsCare Centers, Inc. is not responsible for my personal property, money, or valuables left unattended. I understand that any valuables should be left in my locked car.

### RELEASE OF INFORMATION

I authorize Physical Therapy and SportsCare Centers, Inc. and the therapists involved in my care to release information about my care and treatment: a.) as required to process payment of claims and b.) to other facilities or providers for the continuity of my care. This authorization includes release of information regarding therapy treatment and outcome.

### ASSIGNMENT OF BENEFITS

I authorize my insurance carrier(s) to pay my medical benefits for services rendered directly to Physical Therapy and SportsCare Centers, Inc. I understand that as a courtesy to me, Physical Therapy and SportsCare Centers, Inc. will file an insurance claim with my insurance carrier, but I am financially responsible for charges incurred at this office.

### ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of this office's Privacy Notice.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature if Patient is a Minor Date

# Acknowledgement of Receipt of Privacy Notice

## Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or health care operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

***Please read the following information carefully:***

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Physical Therapy & SportsCare Centers, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any health care operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 2717 S. Arlington Road, Akron, Ohio 44312, Attention: Compliance Officer.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or health care operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information **(leave blank if no restrictions)**: ___

   _____

   _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and health care operations.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.**

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Patient's Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

***To Be Completed by the Practice***

Office personnel: Only complete this section if patient requested restrictions.

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date

# Tallmadge Physical Therapy & SportsCare

**Patient Name**_____ **Date** _____

**1. What is your occupation?** _____ ○ Full Time ○ Part Time

**2. Describe your symptoms** _____

_____

_____

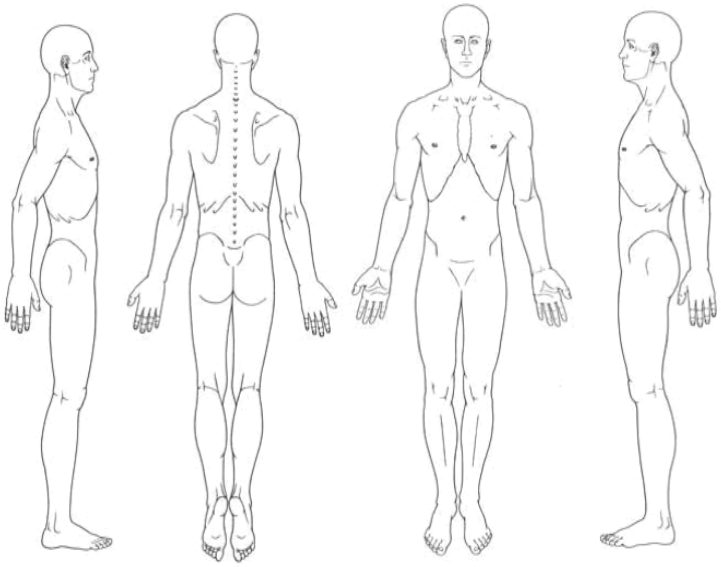
**a. When / How did your symptoms begin?**_____

_____

**3. How often do you experience your symptoms?**

① Constant (76 – 100% of the day)
② Frequently (51 – 75% of the day)
③ Occasionally (26 – 50% of the day)
④ Intermittently (0 – 25% of the day)

**Indicate where you have pain or symptoms?**



**4. What describes the nature of your symptoms?**

① Sharp Pain ④ Shooting
② Dull Ache ⑤ Burning
③ Numbness ⑥ Tingling

**5. Are your symptoms changing?**

① Getting Better
② Not Changing
③ Getting Worse

**6. During the <u>past 4 weeks</u>:**
Indicate the average intensity of your pain / symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

**7. What tests have you had for your symptoms?**

① Xrays date: _____ ③ CT Scan date: _____
② MRI date: _____ ④ Other date: _____

**8. Have you had similar symptoms in the past?** ○ Yes ○ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

① This office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

**9. In general would you say your overall health right now is . . .**

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

**10. Medical History (check any that apply):**

**Heart Disease:**

- ○ Congestive Heart Failure (CHF)
- ○ High Blood Pressure
- ○ Heart Attack (Myocardial Infarction)(MI)
- ○ Atherosclerotic Disease (CAD)
- ○ Angioplasty
- ○ Valvular Disease
- ○ Stents
- ○ Arrhythmia
- ○ Coronary Artery Bypass Graft (CABG)
- ○ Angina

**Lung Disease:**

- ○ Chronic Obstructive Pulmonary Disease (COPD)
- ○ Emphysema
- ○ Asthma
- ○ Recent Pneumonia

**Vascular Disease:**

- ○ Peripheral Arterial Disease
- ○ Acquired Respiratory Distress Syndrome (ARDS)
- ○ Diabetes
- ○ Taking Blood Pressure Meds
- ○ Stroke / TIA
- ○ Chronic Bronchitis
- ○ Hypertension

**General Medical Conditions:**

- ○ Arthritis (rheumatoid/osteoarthritis)
- ○ Allergies
- ○ Neurological Disease (such as MS or Parkinson's)
- ○ Headaches
- ○ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ○ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
- ○ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ○ Hepatitis / AIDS
- ○ Prior Surgery(s):

_____ Date:_____

_____ Date:_____

- ○ Osteoporosis
- ○ Anxiety or Panic Disorders
- ○ Depression
- ○ Previous Accidents
- ○ Kidney, Bladder, Prostate or Urination Problems
- ○ Incontinence
- ○ Hearing Impairment, very hard of hearing, even with hearing aids
- ○ Sleep Dysfunction
- ○ Prosthesis / Implants
- ○ Cancer

**Other Disorders:** _____

_____

**For Patients 65 years of age and older:**

**11. Have you fallen in the past year?** ○ Yes ○ No

If "Yes" to #11, continue to #12

If "No" to #11, Stop

**12. Did you sustain an injury from the fall?** ○ Yes ○ No

**13. Have you had 2 or more falls in the past year?** ○ Yes ○ No

**Patient Signature** _____ **Date** _____

**Tallmadge Physical Therapy & SportsCare**

Patient's Name _____
Date _____

## MEDICATION CHECKLIST

We need to keep a current record of the medications you take. Please take a few minutes to check off any medications you currently take as well as list any we don't have on our checklist. We also need you to list any medications you may be allergic to. Please check only the medications you are currently taking.

| MEDICATION | YES | DOSE |
|---|---|---|
| Aleve | | |
| Amaryl | | |
| Anaprox | | |
| Antibiotic | | |
| Arthrotec | | |
| Aspirin | | |
| Atrovent | | |
| Aventyl | | |
| Baclofen | | |
| Birth Control | | |
| Blood Pressure Medication | | |
| Calcium | | |
| Cardizem | | |
| Catapres | | |
| Celebrex | | |
| Codeine | | |
| Darvocet | | |
| Darvon | | |
| Daypro | | |
| Decadron | | |
| Demerol | | |
| Depakene | | |
| Dexedrine | | |
| Diabeta | | |
| Dilantin | | |
| Elavil | | |
| Estrogen | | |
| Feldene | | |
| Ibuprofen | | |
| Inhaler | | |
| Insulin | | |
| Klonopin | | |
| Lidocaine | | |
| Lorinal | | |
| Lipitor | | |
| Magnesium | | |
| Medrol Dose Pack | | |
| Meridia | | |
| Metformin | | |

| MEDICATION | YES | DOSE |
|---|---|---|
| Morphine | | |
| Motrin | | |
| Muscle Relaxant | | |
| Naprosyn | | |
| Norvasc | | |
| OxyContin | | |
| Paxil | | |
| Percocet | | |
| Plaquenil | | |
| Prednisone | | |
| Premarin | | |
| Prevacid | | |
| Prilosec | | |
| Provera | | |
| Prozac | | |
| Relafen | | |
| Ritalin | | |
| Sarafem | | |
| Sinequan | | |
| Steroids | | |
| Synthroid | | |
| Tamoxifin | | |
| Tegretol | | |
| Therapen | | |
| Tofranil | | |
| Tylenol | | |
| Vicodin | | |
| Zanaflex | | |
| Zoloft | | |
| Zyrtec | | |
| MEDICATIONS NOT LISTED | | |
| | | |
| | | |
| | | |
| | | |
| **MEDICATION ALLERGIES** | | |
| | | |
| | | |
| | | |

# Notice of Protected Health Information Practices (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.**

## Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Physical Therapy & SportsCare Centers, Inc. ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies ad procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

## Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

    a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

    b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

    c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

    a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

    b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

    c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

    d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

    e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

    f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

    g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

    h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

    i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

    j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

## Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.

2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. **When Authorizations are Required**. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.

8. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

9. **Right to Opt-Out of Fundraising Communications**. We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications.

10. **Right to be Notified Following a Breach of Your Information.** If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.

11. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

## Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at 330-245-1791. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact our Compliance Officer at 330-245-1791. All complaints must be submitted to the Practice in writing at 2717 S. Arlington Road, Akron, Ohio 44312. There will be no retaliation for filing a complaint.

## Effective Date

The effective date of this Notice is 9/10/13.