ADE MEDICAL GROUP

General Patient Consent

Consent to Treat

I hereby voluntarily consent to all healthcare services ordered/provided by Ade Medical Group providers (David Ade MD, Thomas Ade MD, and/or their Nurse Practitioners/Physician Assistants). For the remainder of the document the providers will be referred to as "Ade Medcial Group".The health care service may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and test; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations). I consent to examinations, treatments, procedures and blood test ordered by the healthcare provider, which may include blood test for diseases such as hepatitis and HIV AIDS. I understand that I will be asked to sign a separate informed consent for each vaccine to be administered and that I will receive a "Vaccine Information Statement"(VIS) prior to the administration of each vaccine. I understand that there is a separate consent form that I may be asked to sign for testing for infections conditions. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until the center changes its services and ask me to complete a new consent form.

I understand that if this consent is being signed on behalf of a minor, I may be required to sign a separate paternal consent form in order for the minor to receive family planning services. I understand that if this consent is being signed on behalf of a minor, this consent is valid until the minor turns 18, at which time the minor must consent for services on his/her own behalf.

Consent to Bill Insurance and Collect Payment

I understand and agree that health or behavioral health insurance coverage is an agreement between the insurance carrier and myself. I understand that Ade Medical Group will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amounts authorized will be paid directly to Ade Medical Group. However, I clearly understand and agree that all services provided to me are charged directly to me and that I am personally responsible for payment. I authorized Ade Medical Group to furnish information to insurance carriers concerning my illness and treatments.

I acknowledge my responsibility to pay for that care according to the fees established.

In the event that the patient is a minor, I am the parent and/ or guardian of said patient and I agree that I am responsible for all services provided to the patient herein.

HIPAA Acknowledgment of Privacy Practices

I have received a copy of the "Notice of Client Privacy Rights." This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act.

Consent to View Prescription History and Electronic Prescription

I give permission for my medical provider to view all prescriptions filled at other pharmacies using my current prescription insurance plan. This includes checking prescription history with the prescription monitoring program for Illinois and surrounding states. If you reside in multiple states, all states will be checked in the database. I also understand that Ade Medical Group utilizes electronic transmission of my prescriptions through the EMR vendor of their choice.

Consent for Alternate person to bring Minor Child to Appointment

I understand that I, Parent/ guardian, must bring my child to the first appointment with an Ade Medical Group provider, in order to give a complete medical history. Following the first visit, I give permission for the following individual(s) to bring my child to Ade Medical Group for treatment. I understand that by giving permission for this individual(s) to bring my child to their appointment the individual(s) is fully authorized to consent to treatment prescribed by the Ade Medical Group provider.

Alternate individuals that may bring child to Ade Medical Group for treatment:

Name and Relationship: _____

Consent to release Information

May we release test results or appointment information to anyone other than you, (i.e., spouse, child)? Yes or No

If YES, please list first and last name and relationship to you:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

Cell Phone, Text, and Message Policy

We provide courtesy appointment reminders via call/text and possibly other important information that may be placed using a prerecorded message. Initials Initialing here allows us to do that. Please fill the following consent out for additional services for each of your contact numbers:

Cell: ( ) -	Can we leave a detailed message with test results, referral information, appointment times, etc?	**Yes**	**No**
Home: ( ) -	Can we leave a detailed message with test results, referral information, appointment times, etc?	**Yes**	**No**
Work: ( ) -	Can we leave a detailed message with test results, referral information, appointment times, etc?	**Yes**	**No**

Circle your preferred number that we have your permission to leave a confidential voicemail (e.g. lab or test result, prescriptions, appointment information?

Cell **Home** **Work**

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that Resident Physicians, Student Nurse Practitioners, and/or Student Physician Assistants may be involved in treatment and I consent thereto.
4. I understand that mid-level providers (Physicians Assistants and Advanced Practice Registered Nurses) may be involved in treatment and I consent thereto.
5. I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such.
6. I hereby voluntarily give my consent to treatment at Ade Medical Group.
7. I agree with and will adhere to all above policies that are on this form.

Patient or Power of Attorney to sign here:

Patient Signature: _____ Date: _____

POA name and Signature (if applicable): _____ Date: _____

Interpreter/Translator to complete when applies:

I have accurately and completely read/ translated the forgoing document to: _____
Patient Name
in _____, the Patient's or Patient's Legal Representative's primary language. Patient understood all of the terms and
Language
conditions and acknowledged his/her agreement and consent thereto be signed by the document in my presence.

Printed Name of Interpreter/Translated: _____

Signature of Interpreter: _____ Date: _____

Office Use Only

_____

Printed Name of Witness

	_____
Signature of Witness	**Date**

Patient and Center Rights and Responsibilities

Welcome to Ade Medical Group. Our goal is to provide quality health care to qualified persons in this community, regardless of their ability to pay. If we are enrolling new patients, you may be eligible to become our patient. As a patient, you have rights and responsibilities. We have rights and responsibilities also. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read this statement and ask us any questions that you might have.

Human Rights:

1. You have the right to be treated with respect and dignity regardless of race, religion, sex, national origin, sexual orientation, gender identity, political affiliation or ability to pay for services.

Payment for Services:

2. You are required to complete the registration process to determine if you are eligible for discounted fees for services. You are required to give us accurate information about your present financial status and any changes in your financial status as they occur. We need this information to decide how much to charge you and/or bill private insurance, Medicaid, Medicare, and/or identify other benefits for which you may be eligible.
3. You have the right to receive explanations of your bill. You must pay, or arrange to pay, all agreed fees for medical or dental services, as provided by our policies.
4. Federal law prohibits us from denying you primary health care services, which are medically necessary, solely because you cannot pay for these services. However, you are responsible for your fees and need to act in good faith to make arrangement for payment of services received.

Privacy:

5. You have the right to have your interviews, examinations and treatments in privacy. Your medical records are also private. Only legally authorized persons may see your records, unless you request in writing for us to show them to someone else. A complete discussion of your privacy rights is attached in the "*Notice of Client Privacy Rights*." By signing this document you are indicating that you have received this Notice. The Notice details the various rights granted to you under the Health Insurance Portability and Accountability Act.

Health Care:

6. You are responsible for providing us with complete and current information about your health or illness, so we can provide you proper health care. You have the right to, and are encouraged to participate in decisions about your treatment.
7. You have the right to information and explanations in the language you normally speak and in words that you understand. You have the right to information about your health or illness, treatment plan (including risks) and expected outcome, if known. If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to a legally authorized person.
8. You have the right to information about Advance Directives. Please let us know if you need assistance in getting Advanced Directives in place.
9. You are responsible for appropriate use of our services, which includes following our staff's instructions, making and keeping scheduled appointments, and only requesting a "walk in" appointment when you are ill. We may not be able to see you unless you have an appointment. If you do not understand or cannot follow the staff's instructions, please tell us so we can help you.
10. If you are an adult, you have the right to refuse treatment to the extent permitted by law, and to be informed of the risks of refusing such care. You are responsible for the outcome of refusing treatment.

11. You have the right to healthcare and treatment that is reasonable for your condition and within our capability. You have the right to be transferred or referred to another facility for services that we cannot provide. However, Ade Medical Group is not required to pay for services that you get elsewhere. ***Note***: Ade Medical Group is not an emergency facility.
12. If you are in pain, you have the right to receive appropriate assessment and management, as necessary.

AccessHealth Rules:

13. As with any organization, Ade Medical Group has rules for use of our services. Patients are responsible for understanding the rules and using our services in an appropriate manner. Ade Medical Group property or services may not be abused and it is an expectation that all patients treat our employees and facilities with respect. If you have any questions, please ask.
14. Parents are responsible for the supervision of children brought with them to Ade Medical Group. You are responsible for their safety and the protection of other clients, and our property. Please do not leave your children unattended.
15. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause a delay in treating other patients. If you do not keep scheduled appointments or if you cancel your appointment with less than 24 hour notice, you may be charged a late fee of $35.00 (not billable to insurance, this is the patient responsibilty).

Complaints

16. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. We will tell you how to file a complaint. Completed Client Suggestion/Complaint forms shall be reviewed by the appropriate supervisor. You shall receive a response from Ade Medical Group by mail or phone regarding the outcome of your complaint or suggestions. If you are not satisfied with how we handle your complaint, you may file a complaint with the Practice Manager at Ade Medcial Group.
17. At no time will your complaint affect the care you are entitled to receive.

Termination:

18. Ade Medical Group can decide to stop treating you as a patient. If we stop treating you as a patient, you have the right to advance notice that explains the reason for the decision, and will be given 30 days to attempt to find other health services. After notice of termination, we will only provide urgent care for a 30-day period while you find a new provider. We can decide to stop treating you immediately and without notice, if Ade Medical Group has determined that you have created a threat to the safety of the staff and/ or other clients. Other reasons for which we may stop seeing you include:
    a. **Failure to obey Ade Medical Group rules,**
    b. **Intentional failure to report accurate information concerning your health,**
    c. **Intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your doctor,**
    d. **Creating a threat to the safety of the staff and/or other clients, and/or**
    e. **Intentional failure to accurately report your financial status.**

_____	_____
Signature of Patient/Guardian or Power of Attorney	*Signature of Witness (Staff)*
_____	_____
Date	*Date*

ADE MEDICAL GROUP

Appointment and No Show Policy

Ade Medical Group is committed to providing prompt medical care to all of our patients. We understand that situations arise in which patients must cancel their appointments. It is therefore requested that patients who must cancel their appointments provide at minimum a 24 hour notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made in less than 24 hours, we are unable to offer that appointment slot to other patients who wish to be seen. Patients who do not show up or call to cancel their appointment will be considered a **NO SHOW.**

A **NO SHOW** is when a patient fails to keep a scheduled appointment or is more than 15 minutes late. Patients are advised to arrive 10-30 minutes prior to their scheduled appointment to allow time for parking, check-in and required paperwork.

If the patient is delayed and cannot make an appointment on time, the patient must call to advise us of the situation and provide an estimated time of arrival. Any significant delay may require the patient to wait for the next available appointment, which may be with a different provider. If none become available, the patient will be rescheduled.

In the event that a patient has a special circumstance regarding a missed appointment, the patient may contact the clinic to discuss the special circumstance. We understand that there may be issues beyond the patient's control and want to be understanding of special circumstances.

Patients who no show 3 times or more within a 12 month period may be terminated by the provider.

When making an appointment, adult patients must choose between a well visit or a sick visit since both cannot be accommodated on the same day since the patients' insurance often may not pay for both. Only pediatric patients can have both types of visit on the same day.

Due to the current nature of insurance-based medical practices, we ask that patients limit their medical problems to **1 TO 2 ISSUES only**. Should the patient have more medical issues that need to be addressed, the patient must inform our staff when calling for appointments. Our providers may request patients to return for follow-up visits in order to address additional medical concerns.

Multiple family member appointments **must be** scheduled in advance. Family members who are present at the time of another member's appointment, but are not scheduled, will be required to schedule an appointment at a later time.

NO CALL NO SHOWS AND CANCELLED APOINTMENTS (WITH LESS THAN 24 HOURS NOTICE) MAY BE CHARGED A FEE OF $35.00 WHICH IS NOT BILLABLE TO YOUR INSURANCE AND WILL BE YOUR RESPOSIBILITY TO PAY.

I have read and agree to adhere to Ade Medical Group's "Appointment and No Show Policy."

_____ _____

Printed Name of Patient/Guardian or Power of Attorney Date

_____

Signature of Patient/Guardian or Power of Attorney

Rev: 1/22

Patient Portal Informed Consent and User Agreement

Ade Medical Group offers our patients, as a courtesy and an optional service, the use of a secure web page portal ("Patient Portal"). This Patient Portal allows our patients to access their health information online! Patients may also request appointments, submit changes/updates to their demographic information and communicate with the Ade Medical Group staff through the Patient Portal. Use of the Patient Portal is restricted to current patients and is subject to all terms and conditions of the Center's Patient Portal Policies and Procedures.

Purpose of this Form

Ade Medical Group via eClinicalWorks offer a secure way for patients to view certain parts of their health information maintained in an electronic health record, and to communicate with their physician and office staff. While secure messaging can be a valuable communication tool, it has certain risks. In order to manage these risks, there are some conditions of participation. This form is intended to document that you have been informed of these risks and conditions of participation, that you accept the risks, and that you agree to the conditions of participation and to the Center's Patient Portal Policies and Procedures.

How the Secure Patient Portal works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the correct User ID and Password to log into the Patient Portal application.

How to participate in our Patient Portal

Once this form is agreed to and signed, we will send you an e-mail notification that explains how to register and gain entry to the Patient Portal for the first time. This notification will give you the URL (internet address) of the website where you can log in using the user name and temporary password provided. You will then be prompted to change your password to one of your own personal preference. Once this step has been completed, you will be able to view your message in-box and see any current messaging, or you may view, download, or print specific content from your electronic health record. The information you view on your computer is safe and is encrypted in transmission between the Patient Portal website and your computer.

Protecting Your Private Health Information and Risks

Encryption prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping your information and messages secure depends on additional factors:

- Secure messages must reach the correct email address
- Only you (or someone that you have authorized) must be able to access your E-mail, Portal user ID or Password.
- Do not store, send or access messages on a computer, or hand-held device, provided to you by your employer.
- Use a screen saver or close messages so that others nearby cannot read them.
- If you believe that someone has discovered your password, promptly change it using the Patient Portal.
- Never use a public computer to access the Patient Portal.
- If you receive access to health care information which is not yours, you must immediately stop viewing such information and immediately notify the Center via a secure message on the Portal or by phone.

Ade Medical Group and our staff are not responsible for security infractions or intrusions resulting from the patient's failure to follow prudent security measures when accessing the Patient Portal, including those described above, or for network infractions beyond its reasonable control.

Important Information Regarding the Patient Portal

- Patient Portal use is limited to non-emergency communications. In an emergency, call 911 or go to the nearest emergency room.

- Patients should allow 48 business hours to receive a response from the physician or the staff to any communications and requests. Dependent upon volume, a longer period of time may be required before a response is received.
- The Patient Portal does not provide internet based diagnostic, triage and other medical services. A diagnosis can be made and treatment rendered only after the patient sees the physician at the Center.
- All communications via the Patient Portal will be included in the clinical record maintained by the Center.
- Online communication does not replace any of the other ways in which a patient can communicate with Ade Medical Group.
- The Center does not guarantee that the Patient Portal system will be accessible 24 hours a day, 7 days a week. The System may be unavailable, without prior notice, due to routine maintenance or due to circumstances beyond the control of the Center. The Center may suspend or terminate operation of the Patient Portal without advance notice. The Center and its staff shall have no liability or responsibility to anyone who is unable to access the Patient Portal system for any reason.
- The Center does not permit minors to use the Patient Portal, whether or not they are legally emancipated.
- The Center may dis-enroll any individual from use of the Patient Portal at any time, without prior notice and without cause or for cause in its discretion.

Conditions of Participating in the Patient Portal

Access to this secure web portal is an optional service and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service, we will notify you as promptly as possible. By logging onto the Patient Portal, you agree to all terms and conditions of the Center's Patient Portal Policies and Procedures, and any amended or superseded Policies and Procedures adopted by the Center. The Center may amend, supersede or rescind its Patient Portal Policies and Procedures at any time, without prior notice. The Center will make reasonable efforts to post such matters on the Patient Portal. The Center shall have the discretion to determine how its Patient Portal Policies and Procedures apply in a given situation, and its determination shall be final, binding and non-reviewable. The Center is the owner of all of its records and data, whether in electronic, paper or other form, subject to such access, copying and other rights as may be provided to you by federal and state law. If you do not understand, do not agree to comply with or do not consent to our policies and procedures, please do not participate in the Patient Portal. If you have any questions or need further information, please let us know before signing the form.

☐ **I would like to participate in the eCWPatient Portal**

Patient Name _____ DOB _____

Address _____

Email Address _____

Optional: Allow Portal Access to my Health Information to the Following Individual

Name _____ DOB _____ Relationship to Patient _____

Address _____

Email Address _____

By signing below, I agree to participate in the AccessHealth Patient Portal. I acknowledge that I have read and agree to comply with the above Patient Portal Policies and Procedures.

Patient/Guardian Signature_____ Date_____

☐ **I do not wish to participate in the eCW Patient Portal at this time.**

By Signing below, I acknowledge that my information will not be made available to me through the Patient Portal. I confirm that I have been provided with all necessary information regarding access to the Patient Portal, should I choose to participate at a later time.

Patient/Guardian Signature_____ Date_____

Notice of Client Privacy Rights

TO OUR CLIENTS: This notice tells how health information about you may be used and released and what your rights are about your information. **Please read it carefully.**

This notice applies to all of the records of your care created by Ade Medical Group whether made by the center or another provider that is related to the center. Our policies for protecting your health information apply to doctors, nurses and other health care staff who have a need to know to provide care to you. These policies apply to all areas of the center including all center staff, the front desk, billing, and administration. It also applies to any organization or individual with whom we contact for services, such as referral providers.

Your Protected Health Information. As our patient, we create paper and electronic medical records and documents concerning you and your health, as well as the care and services we provide to you. We need this record to provide the best care and to comply with certain legal requirements. We are required by law to:

- make sure that your protected health information is kept private,
- provide you with this Notice of Client Privacy Rights, and
- make sure the law and your legal rights are in effect.

YOUR PRIVACY RIGHTS

You have the right to:

Request Confidential Communications from us. We will not release your health information except as described in this notice. You may ask us to contact you at a different address or phone number. You may ask us to limit the number or type of people who have access to your health information. If you don't want us to contact you at your current address or phone number, **YOU MUST TELL US**. Please make this request in writing to Ade Medical Group, ATTN: Manager, Medical Records.

Receive Confidential Services from us. We are required to protect your privacy while you are in our buildings. We cannot disclose to anyone whether or not you are a client of Ade Medical Group, if you have an appointment or if you are in our building. If you are expecting someone to call or come by for you, to give you a ride, or to be with you during your appointment, **YOU MUST TELL US. We must have your permission to disclose this information**.

Inspect and Copy your Health Information. You may ask to review and get a copy of health information about you that the center keeps for as long as we have it. If you request to review your health information, we will determine whether to allow you to review some or all of the health information you ask for. We may charge a fee for any copies that you ask for. Please make this request in writing to Ade Medical Group, ATTN: Manager, Medical Records.

Request a limit to the health information we disclose. You may ask us not to use or disclose your health information. Your request must describe the specific limits you are requesting. We may deny your request. Please make this request in writing to Ade Medcial Group, Attn: Manager, Medical Records.

Change your health information, if you feel it is wrong or not complete. You may request that we amend the health information the center keeps. If we accept your request to change your health information, the change will become a permanent document in your health care record. Please make this request in writing to Ade Medical Group, Attn: Manager, Medical Records.

Request a list of to whom and when we have released your health information. You can request a list of releases of your health information that the center has made. This list will not include routine releases of your health information for the treatment, payment, or business operations purposes described in this notice. Please make this request in writing to Ade Medcial Group, Attn: Manager, Medical Records.

Receive a paper copy of this notice from us. You may request a copy of this notice at any time.

YOUR RIGHT TO COMPLAIN

Complaints. If you believe that your privacy rights have been violated, you may file a complaint with the center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing, and all complaints will be investigated. You may ask any staff person to give you a complaint form.

HOW WE MAY USE AND RELEASE YOUR PERSONAL HEALTH INFORMATION

Treatment. We use information about you to provide your healthcare treatment or services now or in the future. We may, and most likely will, release your information to doctors, nurses, and other healthcare personnel who are involved in your care.

For Auditing Purposes: We may release your information for auditing purposes of any Institutional, State, or Federal program, as applicable. These programs may include, but are not limited to, the IPAP (Institutional Patient Assistance Program) Bulk Replenishment Programs, DSHS Primary Health Care Program, HHSC Family Planning Program, HHSC Healthy Texas Women's Program, etc.

Payment. We may use and release medical information about services and procedures provided to you so they may be billed and collected from you, your insurance company or a third party reimbursement entity such as Workers' Compensation.

Operational (Business) Uses. We may use and release your health information in order to operate the center efficiently and make sure our patients receive quality care.

Appointment reminders. We may use and release your health information to contact you to remind you about appointments or for medical care that you need to receive. We may mail postcards to your mailing address or leave a message at the phone number you have given us. We may leave messages on your answering machine or with friends or relatives who answer the phone. **IF YOU DO NOT WANT TO BE CONTACTED THIS WAY, YOU MUST TELL US.**

Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

Victims of Abuse, Neglect or Domestic Violence. We may release your health information to law enforcement, social services, or other government agencies authorized to receive the report if we have reason to believe that you are a victim of abuse, neglect, or domestic violence.

Workers' Compensation. We may release your information if required by Workers' Compensation laws and other similar laws and regulations.

Emergency Organizations. In an emergency, we may release information about you for disaster relief so that your family can be notified about your condition, status and location.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may release your health information in response to a court subpoena, court order, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. In response to a court order, subpoena, warrant, summons or other similar process, we may release your health information to law enforcement officials. This could be done in an effort to assist in identifying or locating a suspect, witness or missing person. This could also be done to share information about a victim of a crime, a death believed to involve criminal actions, criminal conduct in progress or crimes committed on Center premises. This could also be done in emergency situations in reporting a crime or sharing details about a crime.

To Prevent a Serious Threat to Health or Safety. We may use and disclose your health information to persons who need to know when necessary, to prevent a serious threat to either your health or safety or the health and safety of others.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement and transplantations.

Public Health Issues and Risks. We may report your health information as required by law or by your authorization concerning certain health conditions to prevent or control disease, injury or disability, births and deaths, child or elder abuse or neglect, reactions to medications or products, recalls of products and notice of exposure to a condition.

Investigations and Government Activities. We may release your health information to a local, state or federal agency for oversight activities authorized by law that may concern inspections, licensure, illegal conduct, or compliance with other laws and regulations including civil rights laws.

Coroners, Medical Examiners and Funeral Directors. We may release your health information to a coroner or medical examiner or funeral directors as necessary for them to carry out their duties.

Military and National Security. If you currently serve in the military or are a veteran, we may release your health information to the military upon proper request. We may also disclose your information to federal officials conducting national security and intelligence activities.

Research. We may take part in research about the use of certain treatment protocols that have proper governmental and center approval. In that case, we would secure your informed consent that will identify all aspects of your involvement, risks and benefits and possible release.

CHANGES TO THIS NOTICE

Changes to this Notice. We reserve the right to change this notice at any time. We will post a copy of the current notice in the center with the effective date in the upper right hand corner of the first page. You may request a copy of the current notice each time that you visit the center for services or by calling the center and requesting that the current notice be sent to you in the mail.

PRIVACY CONTACT INFORMATION

If you have any questions about this notice or wish to file a complaint, please contact the center's Privacy Officer:

Name: Ashley Stichter or Kristi Johnston

Address: 550 30th Avenue Ste 12 Moline, IL 61265

Telephone: (309)762-5513 **Fax:** (309)762-5519