

CONSENT FORM

Must read and sign consent before services are rendered



Dr. Jeffrey Sherman and the entire staff feel privileged that you have chosen us to serve the healthcare needs of you and your family.

We would like to make the experience of seeing your physician almost like visiting a knowledgeable and trusted friend. While maintaining professional standards, your good health is our ongoing priority. We want our patients to feel comfortable which we believe happens through communication and education. We welcome any comments or suggestions that you may have to improve our practice.

OFFICE HOURS

Our office hours are from 8:30 AM to 5:30 PM, Monday through Friday. The office is closed from 12:30 PM to 1:30 PM for staff lunch. Our office is closed Saturday and Sunday.

APPOINTMENTS

It is our policy to call and remind you of your appointment on the business day before your scheduled appointment. If you are not available, we will leave a message unless instructed differently by you.

There may be times when the doctor may be unavailable in the office due to unforeseen professional obligations or emergencies. We apologize in advance for any inconvenience this may cause but we will reschedule your appointment as soon as possible.

PAYMENT AND CO-PAYS

Please be advised that you are responsible for all co-pays and deductibles for both your primary and, if you have one, secondary insurance. If you do not have insurance, payment is expected at the time of the visit.

As a courtesy to our patients, we file insurance with all insurance companies, except third-party, such as auto or personal injury claims. For those that we cannot file, we will provide you with an itemized form to turn in to your insurance company. Please be aware, though, if your insurance company refuses to pay, for any reason other than our error, the bill will become your responsibility.

We are contracted with many insurance companies. It is the responsibility of the patient to obtain the proper referrals from their primary care physicians if your insurance company requires this. Please make sure that we are in the network for your insurance company if your company has a network.

If you require lab work, we will file it with your insurance company on your behalf, however, if it is not covered by your insurance, the bill will be your responsibility.

HEALTH INSURANCE CLAIMS SUBMISSION POLICY

Your insurance is a method for you to receive reimbursement for fees you have paid to our physicians for their services. Having insurance is not a substitute for payment. Many carriers have fixed allowances or percentages based on your contract with them, not with our office. If we participate with your insurance, we will accept the fees we have pre-negotiated with them. It is your responsibility to pay deductible, co-insurance, copays, and non-covered balances.

RELEASE AND ASSIGNMENT

I hereby authorize Jeffrey A. Sherman, MD to apply for benefits on my behalf for services rendered each time I or my child(ren) are present for care. Further, I assign payments from my insurance carrier to Jeffrey A. Sherman, MD for medical services rendered. I understand I am responsible for any amount non-covered by my insurance.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Jeffrey A. Sherman, MD to use and disclose protected health information (PHI) about me or my child(ren) to carry out treatment, payment, and healthcare operations (TPO). Jeffrey A. Sherman, MD Notice of Privacy Practices provides a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. A copy of Jeffrey A. Sherman, MD Notice of Privacy Practices is provided in your new patient package and available upon request. Jeffrey A. Sherman, MD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Jeffrey A. Sherman, MD, 1280 Hwy. 74 S., Suite 100, Peachtree City, GA 30269 ATTN: Privacy Officer.

With this consent, Jeffrey A. Sherman, MD may call my home or other available numbers and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, referrals, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Jeffrey A. Sherman, MD may mail, fax, or e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statement as long as they are marked PERSONAL AND CONFIDENTIAL.

I have the right to request that Jeffrey A. Sherman, MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound to this agreement.

By signing this form, I am consenting to Jeffrey A. Sherman, MD use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jeffrey A. Sherman, MD may decline to provide treatment to me.

WELLNESS EXAMS AND NON COVERED SERVICES

The healthcare providers at Jeffrey A. Sherman, MD believe that wellness exams are important to the health and well being of our patients. We encourage all patients to schedule and to keep their physical appointments.

Many insurance plans do not pay for preventative medical visits, or for medical services that are not deemed medically necessary. Any question related to your coverage limitations should be directed to either your employer or to your insurance company.

By signing this waiver you agree to be fully responsible for payment of your services here, if such services are not covered by your insurance carrier. This includes, but is not limited to, laboratory tests, preventative or well visits, procedures, injections, and immunizations.

Signature of Patient

Signature of Legal Guardian

Date

Date

PATIENT REGISTRATION



PATIENT INFORMATION

Last Name	First Name	Middle Int.
Address		
City	State	Zip
Date of Birth	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone	Work Phone	Cell Phone
Email Address		
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other		

EMERGENCY CONTACTS

Name	Relationship	Phone
Name	Relationship	Phone
Whom May We Discuss Your Medical Information With? <input type="checkbox"/> Myself Only <input type="checkbox"/> Other		

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR MINOR)

Last Name	First Name	Middle Int.
Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone
Date of Birth	Social Security Number	
Relationship		

POLICY HOLDER INFORMATION

Last Name	First Name	Middle Int.
Date of Birth	Social Security Number	Phone
Relationship		

INSURANCE INFORMATION

Primary Insurance

Insured Name	DOB	SSN
Company Name	Policy / ID Number	
Address	Group Number	
City	State	Zip

Secondary Insurance

Insured Name	DOB	SSN
Company Name	Policy / ID Number	
Address	Group Number	
City	State	Zip

HEALTH QUESTIONNAIRE

Please complete this information on the patient. This questionnaire is completely confidential and is to be used only by the doctor in order to provide you with the most comprehensive healthcare.



PATIENT NAME

DOB

HEALTH PROBLEMS IN THE PAST OR PRESENT

HOSPITAL ADMISSIONS AND SURGERIES

MEDICATIONS (IF YOU CARRY A LIST PLEASE GIVE TO THE NURSE TO PHOTOCOPY)

DRUG ALLERGIES

IMMUNIZATIONS (IF YOU HAVE A RECORD PLEASE GIVE TO THE NURSE TO PHOTOCOPY)

- | | | | | |
|------------------------------------|------------------------------------|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> TB | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Pheumonia | <input type="checkbox"/> Rubella | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diphtheria |

CHILDHOOD ILLNESSES

- | | | | | |
|--|----------------------------------|------------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic | <input type="checkbox"/> Mumps | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Other | | | |

HEALTH QUESTIONNAIRE

Please complete this information on the patient. This questionnaire is completely confidential and is to be used only by the doctor in order to provide you with the most comprehensive healthcare.



SOCIAL

Whom do you live with?

Married Single Divorced Widowed Other

Occupation?

Do you exercise? Y N Wear Seatbelts Y N Smoke detectors in house? Y N

Do you/have you ever drink alcohol? Y N How Much? How Often?

Do you/have you ever smoked? Y N Packs per day? Date quit for good?

Do you/have you ever used street drugs? Y N What?

FAMILY HISTORY

Relative	Age Now	Age When Deceased	Illness(es)
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

IF PATIENT IS A FEMALE

Date of last Pap smear?	Number of pregnancies?
Ever have an abnormal Pap smear? Y N	Number of live births?
If yes, how was this treated?	Number of abortions?
Date of last mammogram?	Number of miscarriages?
Any abnormal mammograms? Y N	Have you ever been abused? Y N
What birth control are you using?	

IF PATIENT IS A CHILD

Type of delivery?	Is the child in day care? Y N
Any problems with the pregnancy/delivery? Y N	Any history of abuse to the child? Y N
If yes, explain	What type of discipline do you use?
Any developmental concerns?	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION



FAX TO: (770) 692-0845

PATIENT INFORMATION

Patient Name		Date Of Birth	
Address	City	State	Zip
Phone Number		SSN	
Date Of Request		Date Needed	

AUTHORIZATION (COMPLETE ONE BOX ONLY)

I authorize Jeffrey A. Sherman, MD
to Release Information to:
Name of provider or facility

Address

City State Zip

Phone Number

I authorize Jeffrey A. Sherman, MD
to Obtain Information from:
Name of provider or facility

Address

City State Zip

Phone Number

PURPOSE FOR THIS REQUEST (CHECK ONE BOX ONLY)

- Healthcare Insurance coverage Legal Personal Other

TYPE OF RECORDS REQUESTED (CHECK ONE BOX ONLY)

- Progress Notes Diagnostic Reports Operative Reports
 Entire Copy Of My Record Other (describe):

AUTHORIZATION VALID FOR (CHECK ONE BOX ONLY)

- This request only One year from the date of this authorization

STATEMENT TO RELEASE PROTECTED HEALTH INFORMATION

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to Jeffrey A. Sherman, MD, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records, not to exceed 89¢ per page.

Note: Medical records are faxed in cases of medical necessity only

Signature of patient or representative

Date

Relationship to patient (if requester is not the patient)

FOR INTERNAL USE ONLY

DATE RECEIVED:

DATE PROCESSED:

INITIALS:

CANCEL / NO SHOW POLICY

It is the policy of Jeffrey A. Sherman, MD that patients need to report for their scheduled appointments!

In the case that a patient is unable to make their scheduled appointment the patient must give 24 hours advance notice to the front office staff by calling (770) 631-1344.

In the event a 24 hour notice is not given a fee of \$25.00 will be assessed and \$40.00 for any missed procedures.

In addition, if three (3) or more appointments are missed consecutively, Jeffrey A. Sherman, MD respectfully reserve the right to terminate our relationship with the patient. These fees will be due at the beginning of the patient's next scheduled appointment and must be paid in full at that time.

If the patient does not comply with this policy or if the patient refuses to pay a Cancel/No-Showfee, the patient hereby gives Jeffrey A. Sherman, MD permission to seek payment for said fees if applicable.

NOTE: THESE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY!

Signature of Patient

Date

Signature of Legal Guardian

Date

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

A. OUR COMMITMENT TO YOUR PRIVACY

Our office is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. In conducting our business, we will create records regarding you and the treatment and services we provide to you. Our privacy policies and procedures have long been in practice to maintain our patients' confidentiality. These policies and procedures have evolved as the needs of technology and medical practices change. These policies and procedures as outlined in this Notice will continue to be monitored and may change when appropriate.

The United States Congress has passed the Health Insurance Portability and Accountability Act. We are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain in our office concerning your PHI. We are required by law to maintain the confidentiality of health information that identifies you. By law, we must follow the terms of the Notice that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in regard to your PHI
- Our obligations concerning the use and disclosure of your PHI

We may change the terms of our Notice, at any time. The new Notice will be effective for all PHI that we maintain at that time. You may request a copy of our most current Notice at any time. We will post a copy of our current Notice in our offices in a visible location at all times and on our website at www.lifeboatmedicalassociates.com.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer
1280 Hwy 74 S., Suite 100
Peachtree City, GA 30269

C. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS

The following are examples of the types of uses and disclosures of your PHI that our office may make under this Notice. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

1. Treatment. Our office will use and disclose your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our office - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others such as hospitals, specialists, home health agencies or your primary care physician in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

a. Appointment Reminders/Returning Your Phone Call/Treatment Options Health Related Benefits.

Our office will try to disclose only the minimum necessary PHI for our patients while completing these tasks and may leave messages in Voice Mail.

b. Release of Information to Family/Friends.

Our office may release your PHI to your spouse, friends and/or family members that are involved in your/the patient's care unless you request in writing, as described below, that such disclosures not be made.

2. Payment. Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to your health plan to obtain approval for the hospital admission. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

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3. Health Care Operations. Our office may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our office may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our office.

a. Disclosures Required By Law. Our office will use and disclose your PHI when we are required to do so by federal, state or local law.

b. Mailings. Our office may use your name and address for mailings regarding services offered by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these mailings not be sent to you.

c. Business Associates. We will share your PHI with third party “business associates” that perform various activities (e.g., billing, transcription services) for the office. Whenever an arrangement between our office and a business association involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information without your consent, authorization or opportunity to object:

1. Public Health Risks/Serious Threats to Health or Safety. Our office may disclose your PHI to public health authorities that are authorized by law to collect such information. We may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. Examples: Centers for Disease Control, Food and Drug Administration, Social Service Organizations.

2. Health Oversight Activities. Our office may disclose your PHI to health oversight agencies for quality accreditation or other activities authorized by law. Examples: Tumor Registries, licensure, investigations, inspections, audits, surveys, or disciplinary actions (such as civil, administrative, and criminal procedures or actions), or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Legal Proceedings. Our office may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

4. Law Enforcement. Our office may also disclose your PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include, but are not limited to, (1) legal processes and other proceedings required by law, (2) limited information requests for identification and location purposes, (3) requests pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on our premises, and (6) medical emergency (not on our premises) and it is likely that a crime has occurred.

5. Abuse or Neglect. Our office may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6. Deceased Patients. Our office may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties.

7. Research. Our office may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our office; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

8. Military. Our office may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our office may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our office may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' Compensation. Our office may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our office communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our office will accommodate reasonable requests, however our office is not required to agree to every or any restriction that you may request. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use and/or disclosure of your PHI for treatment, payment and/or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request such a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our office's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our office may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our office may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our office. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our office will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for our office; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our office, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our office has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our office is not required to be documented. Examples: the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before January, 2004. The first list you request within a 12-month period is free of charge, but our office may charge you for additional lists within the same 12-month period. Our office will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our office will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. In addition, an authorization may be requested for uses and disclosures that are identified in this Notice. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this Notice or our health information privacy policies, please contact the Privacy Officer.

Adopted this 1st day of January, 2004.

Jeffrey A Sherman, M.D., President

HOW DID YOU HEAR ABOUT US?

Please tell us how you heard about our practice. Your information will not be

