New Patient Information

Date _____ Last Name _____ First _____ M _____

Briefly describe the reason for today's visit _____

_____

Gender: Male Female DOB _____/_____/_____ SSN _____-_____-_____

Address _____ ZIP _____ City _____State_____

Home Phone _____Mobile _____Consent to text: YES/NO Work Phone_____

Which number would you prefer we call (please circle) -- Home Work Mobile

Email_____

Language(s) Spoken _____ Race _____Ethnicity_____

Marital Status_____

Employer(s) Name _____ Occupation _____

If patient is a **minor**, Guardian: Last Name _____ First _____ M _____

Guarantor/Responsible Party: Patient's relation to Guarantor _____

Guarantor Last Name _____ First _____ DOB _____/_____/_____

Guarantor address if different than patient: Street _____ Zip _____

City _____ State _____ SSN _____-_____-_____ Home Phone _____

Work _____ Mobile _____

How did you hear about us (please circle)? Google – Yahoo – Internet – Yellow Pages – Verizon Super Pages – YP.com –

A Physician: _____ Family/Friend: _____

Other:_____

Referring Physician Name _____Phone_____

PCP/Primary Care Physician Name _____Phone_____

Permission for Treatment

I, the undersigned, herby voluntarily consent to medical care/diagnostic treatment and/or surgical treatment by Davis Facial Plastic Surgery deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature _____ Date _____

Authorization and Assignment

I request that the payment of authorized Medicare or insurance benefits be made either to me or on my behalf for any services furnished by Davis Facial Plastic Surgery. I authorize any holder of medical information about me to release to my insurance carriers or CMS-Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits related to the services.

I hereby authorize Davis Facial Plastic Surgery to furnish information to my insurance carriers or CMS concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s) or CMS to make payment directly to Davis Facial Plastic Surgery for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me.

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that my insurance carriers or CMS do not cover all office services/procedures. **I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services rendered.** I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature _____ Date _____

Designated Relative

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations), and/or in case of emergency contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Release of Confidential Information

I, _____ Date of birth _____

(Please print your name)

authorize Davis Facial Plastic Surgery to release any and all medical information to physicians or medical facilities regarding my care. The information to be released may include office notes, laboratory tests, radiology studies and other testing and information. I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider; the released information may no longer be protected by federal privacy regulations. I understand that this consent shall be valid for a period of 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information had already been released in reliance upon this authorization. I further understand that the confidentiality of this information may be protected by Federal Regulations (42CFR, Part II) prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

_____ _____ _____

Printed name of patient/Guardian Signature of patient/Guardian Date

(Pg 3) Date _____ Name _____

Medications

Please list ALL medications that you take including non-prescription supplements and medicines:
❑ I DO NOT USE any medications regularly
Medical History Continued:
Skin Cancer: Type and Site Below
❑ Melanoma
❑ Squamous Cell
❑ Basal Cell

Medical History

Please mark ALL that apply to YOUR medical history:	
❑ I DO NOT HAVE any of the below	
❑ Anemia	❑ Asthma
❑ Aortic Aneurysm	
❑ Antibiotics for Your Heart During Dental Work	
❑ Anxiety and/or Depression	
❑ Arthritis and/or Gout	
❑ Carotid Artery Blockage	
❑ Clot in Legs or Lungs	
❑ Diabetes	
❑ Diverticulitis	
❑ Eating Disorder	
❑ Emphysema or COPD	
❑ Head Injury	
❑ Heart Attack	
❑ Heart Catheterization and/or Stents	
❑ Heart Rhythm (Fast, Slow or Irregular)	
❑ Heart Valve Problems	
❑ Hepatitis	
❑ Hiatal Hernia	
❑ High Blood Pressure/Hypertension	
❑ High Cholesterol	
❑ HIV	
❑ Irritable Bowel Syndrome	
❑ Pacemaker	
❑ Reflux (GERD)	
❑ Sickle Cell Disease or Trait	
❑ Sleep Apnea	
❑ Stroke or TIA/Mini-Stroke	
❑ Thyroid Disease/Problems	
❑ Treatment for Alcoholism or Substance Abuse	
❑ Ulcer(s)	
Women: ❑ Breast Lump	❑ Endometriosis

(Pg 4) Date __________________ Name ____

Allergies

Please list ALL allergies you have to medications

❑ I HAVE NO allergies

Allergen(s):	Reactions:

Surgical History

Please mark all surgeries that apply, and give date and year:

Procedures	Date-Mo/Yr	Procedures	Date-Mo/Yr
❑ Adenoids		❑ Men: Prostate surgery	
❑ Appendix		❑ Men: Vasectomy	
❑ Arthroscopy		❑ Neck Cyst Removed	
❑ Carotid Artery		❑ Neck Mass Removed	
❑ Cataract Surgery		❑ Pacemaker	
❑ Colon Surgery		❑ Sinus Surgery	
❑ Colonoscopy		❑ Spine Surgery, Back	
❑ Deviated Nasal Septum		❑ Spine Surgery, Neck	
❑ Ear Surgery		❑ Thyroid Surgery	
❑ Esophagus Scope Exam		❑ Tonsils	
❑ Gallbladder		❑ Tracheotomy	
❑ Heart Bypass		❑ Vocal Cord Surgery	
❑ Heart Valve		❑ Women: Breast Lump	
❑ Hernia Repair		❑ Women: Hysterectomy	
❑ Joint Replacement		❑ Women: Tubes Tied	

❑ Other Surgeries:	Date-Mo/Yr

ANESTHESIA HISTORY

Please mark all that apply to you:

❑ Difficult Intubation	❑ Fever Related to Anesthesia
❑ Excessive Nausea From Anesthesia	❑ Slow to Awaken From Anesthesia
❑ Family with Anesthesia Problems	❑ Other:

Other Medical History Continued (Use Back of Sheet as Necessary):

Dean G Davis, MD, FACS • DavisFacialSurgery.com • *Facial Plastic and Reconstructive Surgery • Board Certified and Fellowship Trained*
A Division of Select Physicians Alliance, PL • Tampa: 3440 W. Dr Martin Luther King Jr Blvd • Ste 101 • Tampa Florida 33607 • P: 813.877.7917 • F: 813.877.7918

(Pg 5) Date _____ Name _____

Family History

Please mark the box below any listed family member or members who have had any of following:				
Family Members:	**Father**	**Mother**	**Siblings**	**Children**
	Alive: ❑Yes ❑ No	Alive: ❑Yes ❑ No		
Hypothyroidism				
Hearing Loss				
Dizziness				
Migraine				
Cancer-Site and Type:				
Heart Disease				
Stroke				
Diabetes				
High Blood Pressure or Hypertension				
Mental Illness				
Allergies or "Hay Fever"				
Anemia				
Arthritis				
Asthma				
Bleeding Disorders				
Emphysema or COPD				
Lupus, Sjogren's, Wegener's				
Parkinson's/Tremors/Movement Problem				
Sickle Cell or Trait				
Sleep Apnea				
Thyroid Problem				
Other:				

Pharmacy Name:_____Phone:_____Fax_____

Address_____

Social History: Do you smoke or use tobacco products: Yes/No

Did you ever smoke? Yes/No

Do you drink alcohol? Yes/No

How much?

Do you use Recreational Drugs? Yes/No

Review of Systems: What is your Height? _____ Your Weight? _____

Photography Consent Form

In connection with the medical services I have received from this office, Dr. Davis uses photography to gauge progress and healing. Your photos may also be used for marketing purposes, insurance submission or for photo examples for patients seeking a similar procedure. Please select below how you would like your photos to be used:

Internet, Media and/or Marketing: The photos may be used for marketing, media and advertisement purposes, such as internet posting, professional journal inclusion, brochures, or for informational seminars or lectures. Use of the photograph will not identify patient by name.

❑ Yes ❑ No

In-Office Use: The photos may be used to illustrate an example of a specific procedure to a prospective patient within the specific confines of the offices, or to be seen by a limited group of prospective patients at an assembly. Use of the photograph will not identify patient by name.

❑ Yes ❑ No

OR

Chart Use Only: I would like my photos to remain and be viewed in my chart.

❑ Yes

My consent allows my photograph to be submitted to insurance carrier(s), CMS-Centers for Medicare & Medicaid Services or other third parties in the case that the insurance company has requested photography in regards to my care. It also waives all rights of compensation which may result in the use of my photograph.

_____ _____

Signature Patient Name or Guardian Date of Birth

_____ _____

Print Patient Name or Guardian Guardian Relationship to Patient

(Pg 7) Date _____

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

• **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.

• **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events. Note that these databases may be incomplete if your pharmacy does not participate in database sharing. Neither will this list include over-the-counter medications and supplements/vitamins which you use. This list will not contain information on how well you utilized the prescriptions or why you may have stopped the prescription. Thus, we still need you to bring us a list of all medications and supplements which you use.

• **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or is partially filled.

• **Allergy** - To the degree you have supplied allergy information, this database should provide an allergy list but if you have developed an allergy which you have not told a participating pharmacy service about, it will not be listed. Thus, a complete list of your allergies, including the type of allergic reaction you experienced.

By signing this consent form you are agreeing that Davis Facial Plastic Surgery (A Division of Select Physicians Alliance, PL) can request and use your prescription medication history from other healthcare providers, your pharmacy and/or insurers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Davis Facial Plastic Surgery (A Division of Select Physicians Alliance, PL) to enroll me in the Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____	_____
Signature of Patient Name or Guardian	Date of Birth
_____	_____
Print Patient Name or Guardian	Guardian Relationship to Patient

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

You may decline to sign this acknowledgement.

I have received, or declined, a copy of the Notice of Privacy Practices.

Patient Name (Print): Date of Birth

_____ _____

Signature of Patient or Legal Representative:

_____

If Legal Representative, list Relationship to Patient:

_____

Date:

_____

For Office Use Only: We were unable to obtain this written acknowledgement because:

_____

_____

Initials: _____

Date: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of July 31, 2013

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.

If you have any questions or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer, for Select Physicians Alliance ("SPA") Sheryl A. Watts, COO, at 1149 Nikki View Dr., Brandon, FL 33511 or call: (813) 571-7184.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing SPA's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). SPA is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that SPA maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by SPA and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits SPA to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. SPA will comply with whichever law is stricter.

1. **Treatment**: SPA may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, SPA may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, SPA may contact you to remind you of a scheduled appointment.

2. **Payment**: SPA may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, SPA may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, SPA may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.

3. **Health Care Operations**: SPA may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of SPA's health care professionals, business planning and development, business management and general administrative activities. For example, SPA may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. **Required by Law**: SPA may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health**: SPA may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence**: SPA may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and SPA believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities**: SPA may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. **Judicial and Administrative Proceedings**: SPA may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes**: SPA may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, SPA is not able to obtain your consent; (d) if the information relates to a death SPA believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of SPA ; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors**: SPA may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. SPA may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research**: SPA may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safety**: SPA may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions**: SPA may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation**: SPA may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, SPA may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) SPA has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure**: You have the right to request that SPA restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that SPA restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, SPA is not obligated to agree to any restriction that you request. If SPA agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). SPA will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not SPA will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Marketing and Sale of PHI**: Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization.

19. **Fundraising**: SPA may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications**: You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from SPA in alternative means or at alternative locations. SPA will accommodate all reasonable requests, but certain conditions may be imposed.

To request that SPA make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. SPA will not ask why you are making such a request.

21. **Access to PHI**: You have the right to inspect and obtain a copy of your PHI maintained by SPA. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that SPA is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, SPA may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits SPA to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. SPA will comply with the decision of the reviewing health care professional.

22. **Amending PHI**: You have the right to request that SPA amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. SPA may deny your request if it does not contain a reason that supports the requested amendment. Additionally, SPA may deny your request to have your PHI amended if it determines that: 1) the information was not created by SPA and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach**: SPA will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI**: You have the right to request a listing of certain disclosure of your PHI made by SPA during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. SPA will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. SPA will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice**: You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26. If you believe that your privacy rights have been violated, you may file a complaint with SPA or with the Secretary of Health and Human Services. To file a complaint with SPA, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. SPA WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.