Kentucky vein care

Glen W. Simons, MD
Phone: (859) 455-VEIN (8346)
Fax: (859) 455-8866

3229 Summit Square Place, Suite 150
Lexington, Kentucky 40509
KVC@KYVeinCare.com

Dear Patient;

Dr. Glen Simons and staff would like to welcome you to our practice.

Please complete the attached forms prior to your initial visit. **These forms *must* be mailed back to our offices prior to your appointment. *If we are unable to confirm your appointment and do not have your forms on file, your appointment will be cancelled.***

You must DRINK a minimum of 16oz of WATER 45 minutes prior to your appointment! This helps with the ultrasound process.

Please bring your shortest, loose-fitting shorts to all your appointments. Avoid wearing jean shorts.

Please make sure that we have a current phone number on file. **If we are unable to confirm your appointment, your appointment will be cancelled. If you do not receive a call from us by ONE day prior, please call to confirm.**

We provide timely, personal services to our patients, so we do not overbook; your time is your time. Please extend the same courtesy to our office staff and patients. If you need to reschedule your appointment, please do so at least 48 hours prior to your appointment. This allows us to bring in patients who are waiting for an earlier appointment. Patients who fail to provide advanced notice twice will not be rescheduled.

Please bring a photo ID and your insurance identification card.

All co-pays, deductibles, and/or other fees *must* be paid at the time of service.

Feel free to call us with any questions or concerns that you may have at (859)455-8346. We look forward to your visit.

Sincerely,

Dr. Glen Simons and Staff

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Lexington, Kentucky 40509

Patient Information:

First Name: _____ Last Name: _____ Date of Birth: ____/____/_____

Street: _____ Zip Code: _____

City: _____ State: _____ Gender: □ Male □ Female

Social Security #: _____-____-_____ Driver's License #: _____ Email: _____

Cellular Telephone: (____) ____-_____ Work Telephone: (____) ____-_____ Home Telephone: (____) ____-_____

Employment Status: □ Employed □ Retired □ Disabled Occupation: _____

Employer: _____ Employer's Street: _____

City: _____ State: _____ Zip Code: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Family Physician: _____ Physician Telephone #: (____) _____-_____

Referred By: □ Physician □ Employee □ Friend □ Insurance Company □ Internet □ Magazine
□ Newspaper □ Patient □ Phone Book □ Radio □ Television (WKYT or WYMT please circle)
□ Other
Please provide name of Referral if applicable: _____

Pharmacy: _____ Telephone #: (____) _____-_____

Emergency Contact: _____ Relationship: _____ Telephone #: (____) _____-_____

Insurance Information:

Primary Insurance: _____ Policy #: _____

Group #: _____ Insured Name: _____

SSN of Responsible Party: _____-____- _____ Date of Birth of Responsible Party: ____/____/_____

Responsible Party Name (other than patient): _____

Relationship to Patient: _____ Co-Pay (if known): _____

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Glen W. Simons, MD, PSC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information:

I hereby authorize Dr. Glen W. Simons, MD, PSC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Glen W. Simons, MD, PSC on behalf of myself and/or my dependents, and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of treatment.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid at the original.

Signature: _____ **Date:** ____/____/_____

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Medical History:

First Name: _____ Last Name: _____ Gender: □ Male □ Female

Date of Birth: ____/____/_____ Height: ____'____" Weight: _____lbs

Briefly describe current symptoms: _____

How long have you had this problem? _____ □ Pain □ No Pain Severity (0=none to 10=severe) _____

Side: □ Left □ Right □ Both Location: □ Groin □ Thigh □ Knee □ Calf □ Ankle □ Foot □ Other: _____

Onset: □ Predictable □ Unpredictable Triggered By: □ Exercise □ Elevation □ Sleep □ Cold □ Heat □ Position □ Activity

Made Worse By: □ Standing □ Standing for long periods of time □ Wearing compression hose □ Not wearing compression hose

Made Better By: □ Resting □ Walking □ Elevation □ Using Heat □ Using Cold □ Wearing compression hose

Have you worn compression hose? □ Yes □ No If yes, How long did you wear them? _____

Do you take analgesics (Motrin, Advil, Tylenol, Aleve, etc.) □ Yes □ No How often: _____ For how long: _____

Discoloration: □ Bruised □ Red □ Purple □ Rash □ Brown □ Ulcerated □ Other: _____

History: □ Deep Venous Thrombosis □ Pulmonary Embolus □ Superficial Phlebitis □ Previous Venous or Arterial Surgery
□ Varicose or Spider Vein Treatments □ Laser □ Sclerotherapy □ Surgery When: _____

Please check and/or list ALL illnesses for which you have received medical attention:

□ None	□ Bleeding Disorders	□ Depression	□ Hepatitis	□ Seizures
□ Anemia	□ Blood Clots	□ Diabetes	□ High Blood Pressure	□ Stroke
□ Angina	□ Cancer	□ Diverticulitis	□ Kidney Disease	□ Thyroid Disease
□ Arthritis	□ Cirrhosis	□ Emphysema	□ Low Blood Pressure	□ Ulcer Disease
□ Asthma	□ Chronic Bronchitis	□ Heart Attack	□ Migraine Headaches	□ Tuberculosis
□ Bladder Infections	□ Crohn's Disease	□ Heart Murmur	□ Mitral Valve Prolapse	□ Ulcerative Colitis

□ Other: _____

Please check and/or list ALL surgeries:

□ None	□ Cataracts	□ Hernia	□ Orthopeic Surgery	□ Tonsillectomy
□ Appendix	□ Colon Surgery	□ Hysterectomy	□ Pacemaker	□ Tubal Ligation
□ Breast Surgery	□ D & C	□ Lung Surgery	□ Prosthesis	□ Ulcer Surgery
□ Cardiac Cath	□ Gallbladder	□ Open Heart Surgery	□ Thyroid Surgery	□ Vascular Surgery

□ Other: _____

Do you have an artificial joint or hardware? □ Yes □ No Location: _____

Have you ever been treated for MRSA, When ? _____

Please list ALL medications (including herbal and over the counter) you currently take: □ None

_____

_____

Drug Allergies: _____ □ None

History of reaction to iodine, shellfish, or X-ray contrast: □ Yes □ No If yes, type of reaction: _____

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Social History

Name: _____ Birthplace: _____

Tobacco: □ None □ Pipe □ Snuff □ Cigars □ Cigarettes # of packs per day: _____ # of years: _____

Coffee: □ None □ Yes # of cups per day: _____ Tea: □ None □ Yes # of cups per day: _____

Alcohol: □ None □ Beer □ Wine □ Hard Liquor Weekly amount : _____

Family History: Please write down **ALL** health information for each of the following pertaining to your family

Father: □ Alive; List current health problems : _____

□ Deceased; List cause of death: _____

Mother: □ Alive; List current health problems : _____

□ Deceased; List cause of death: _____

Brothers: _____

Sisters: _____

Father's Family: _____

Mother's Family: _____

Review of systems:

Do you now have or have you had within the past year:

Weakness or paralysis	□ Yes □ No	Palpations or fluttering of the heart	□ Yes □ No
Tire easily or weakness	□ Yes □ No	Leg cramps on walking or at night	□ Yes □ No
Recent weight changes	□ Yes □ No	Enlarged veins	□ Yes □ No
Change in appetite	□ Yes □ No	Difficulty swallowing	□ Yes □ No
Sensitivity to cold or heat	□ Yes □ No	Heartburn	□ Yes □ No
Headaches	□ Yes □ No	Frequent belching	□ Yes □ No
Easy bleeding or bruising	□ Yes □ No	Abdominal cramping	□ Yes □ No
Double Vision	□ Yes □ No	Nausea	□ Yes □ No
Blurred Vision	□ Yes □ No	Vomiting	□ Yes □ No
Do you wear glasses or contacts?	□ Yes □ No	Rectal bleeding	□ Yes □ No
Date of last eye examination: ____/____/____		Black tarry stools	□ Yes □ No
Ringing in the ears	□ Yes □ No	Dark urine	□ Yes □ No
Ear pain	□ Yes □ No	Frequent urination	□ Yes □ No
Decrease in hearing	□ Yes □ No	Increase in thirst	□ Yes □ No
Frequent nosebleeds	□ Yes □ No	Painful urination	□ Yes □ No
Persistent hoarseness	□ Yes □ No	Blood in urine	□ Yes □ No
Sore throat	□ Yes □ No	Lack of sex drive	□ Yes □ No
Lump in breast	□ Yes □ No	Hemorrhoids	□ Yes □ No
Discharge from nipple	□ Yes □ No	Joint pain or stiffness	□ Yes □ No
Chronic or frequent cough	□ Yes □ No	Swollen joints	□ Yes □ No
Shortness of breath	□ Yes □ No	Muscle cramps or spasms	□ Yes □ No
Bloody sputum	□ Yes □ No	Sleeplessness	□ Yes □ No
Wheezing	□ Yes □ No	Seizures	□ Yes □ No
Chest pain or discomfort	□ Yes □ No	Depression	□ Yes □ No
Purple fingers or lips	□ Yes □ No	Memory loss	□ Yes □ No
Swelling of hands, feet, or ankles	□ Yes □ No	Poor coordination	□ Yes □ No
Difficulty in breathing	□ Yes □ No	Dizziness or fainting spells	□ Yes □ No

Men

Discharge from penis	□ Yes □ No
Pain or lump in testicles	□ Yes □ No
Impotence	□ Yes □ No

Women

Age period began: _____ years old

Date of last menstrual cycle: ____/____/____

Date of last pelvic examination: ____/____/____

Date of last mammogram: ____/____/____

Number of pregnancies: _____

Birth control pills	□ Yes □ No
Hormone replacement therapy	□ Yes □ No

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Acknowledgement of Receipt of Privacy Notice and Disclosure Notice

I have been presented with a copy of Glen W. Simons, MD, PSC's ***Notice of Privacy Policies,*** detailing how my information may be used and disclosed as permitted under federal and state law. By signing this document, I consent that I fully understand the contents of the Notice.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** ____/____/_____

If not signed by patient, please indicate relationship to patient:

Relationship: _____ **Witnessed by:** _____

I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Our office, at our discretion of the medical staff, routinely discloses information such as, but not limited to, appointment time and date, laboratory results, account information (financial), and medication information to family members (parent, spouse, sibling, etc.). Information of extremely private nature is never disclosed to anyone other than the patient (abortion history, STD screenings, etc.). Please indicate below should you wish information shared or restricted:

- Share appointment information with spouse □ Yes □ No
- Share appointment information with family members □ Yes □ No
- Share treatment information with spouse □ Yes □ No
- Share treatment information with family members □ Yes □ No
- Share medication information with spouse □ Yes □ No
- Share medication information with family members □ Yes □ No
- Share financial information with spouse □ Yes □ No

It is the policy of this office to share your medical information with your primary care and/or your referring physician. If you do not wish this information to be shared with your doctor(s) please indicate by checking the NO box:

- Share my medical record with my referring and/or primary care physician □ Yes □ No
- Other allowed disclosure or restriction: _____

Signature: _____ **Date:** ____/____/_____

Note: The patient may change this information and/or restriction upon request.

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, document date and time the notice was presented to patient and sign below.

Presented on: ____/____/_____ at ____:____ am/pm

By (name and title): _____

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Photography/Video Release Form

I hereby grant to Glen W. Simons, MD., PSC, the right to use and publish photographs/videos of me, or in which I may be included in, for library publications, electronic reproductions (websites) and/or promotional materials or any other purpose and in any manner or medium.

The photographs will not include any personal information about me, will not show a personally identifiable image (i.e. face, birthmarks, etc.) and that my identity will not be revealed in accordance with HIPAA rulings.

In addition, I grant my permission to alter the same without restriction; and to copyright the same. I hereby release the photographer and Glen W. Simons, MD., PSC, from all claims and liability relating to said photographs/videos.

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Office Representative Date Signed

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Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. **Please read each section carefully and sign the bottom of the page to indicate that you fully understand each section**. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

- We value the time we have set aside to treat you. We do not double book appointments. If you are not able to make an appointment, we require a 24-hour notice. ***There is a $50.00 charge for a missed appointment and a $500.00 for a missed surgical appointment.***
- If you are more than 15 minutes late for your appointment, we will do our best to accommodate you; however, if the schedule does not permit then you must reschedule your appointment.
- We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Insurance Plans

- It is your responsibility to keep us update with your current insurance information. ***If the insurance information you provide is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct insurance company for reimbursement.***
- It is your responsibility to understand your benefit plan with regard to covered services
- It is your responsibility to know if a written referral or authorization is require to see a specialist

Financial Responsibility

- According to your insurance plan, you are responsible for any and ***ALL*** *co-payments, deductibles, and coinsurances*
- ***Co-payments*** are due at the time of service. A ***12.9% interest fee*** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day
- Self-pay patients are expected to pay for services in ***FULL*** at the time of the visit
- If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement
- Patient balances are billed on receipt of your insurance plan's explanation of benefits. Your remittance is due within ***10 business days*** of your receipt of your bill
- If previous arrangements have ***not*** been made with the Office Manager, any account balance outstanding longer than ***28 days*** will be charged a ***1.1% interest fee*** for each 28 day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency and a fee of 30% of the remaining balance will be added.
- For scheduled appointments, prior balances must be paid prior to the visit
- If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file
- We accept cash, checks, Visa, and MasterCard credit and debit, and Care Credit
- A $30.00 fee will be charged for any checks returned for insufficient funds

Forms

Family and Medical Leave Act forms are $25.00. Payment is due when forms are dropped off. We require a minimum of 3 business days turnaround time.

Transfer of Records

One (1) free copy of medical records can be obtained for each patient, non-inclusive of postage. Additional copies are provided for a $0.25/page fee (minimum of $10.00 including postage) or $25.00 maximum fee for large charts not including postage

Consent

If at any time I provided a wireless telephone number or email address at which I may be contacted, unless I notify the office in writing, I consent to receive calls, text messages, and/or email communications regarding billing and payment for services. calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text message or any other form of electronic communication from the doctor, affiliates, contractors, services, clinical providers, attorneys or agents including collection agencies.

Signature: _____ **Date:** _____/_____/_____

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Directions to Kentucky Vein Care

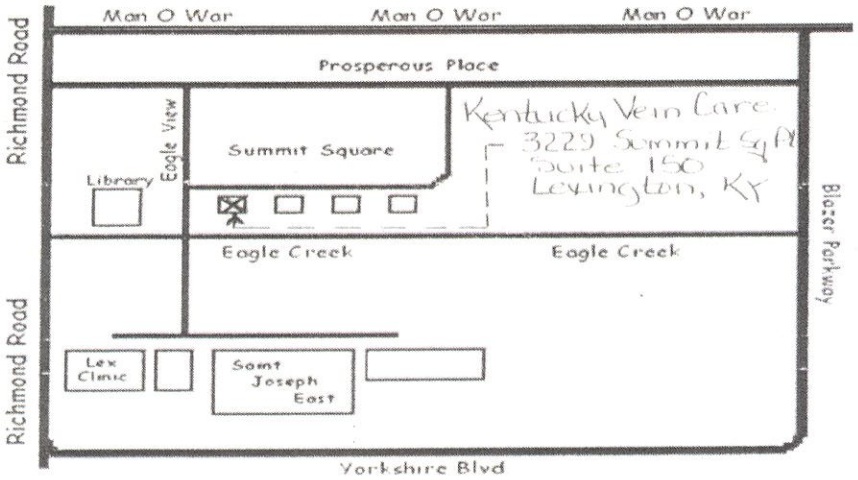
Please bring these with you. The office can be challenging to find.

From I-75

- I-75 **SOUTH** take exit 104 – Athens/Lexington. Take a ***RIGHT*** onto Richmond Road.
  - Stay in ***RIGHT*** lane on Richmond Road for approximately 4.5 miles
  - Take a ***RIGHT*** at the traffic light onto North Eagle Creed Drive. (Dealership will be on the left hand side of the road.
  - Take the ***FIRST*** street on the ***LEFT***, *Eagle View Lane*. On your ***RIGHT*** you will see
  - Central Brace and Prosthetics, on the back of that building is "Walden's Photography". We are next door to Walden's. (Take the ***FIRST*** Street on the ***RIGHT***, *Summit Square Place*. You will see the first building is 3229, take the ***FIRST DRIVE-WAY*** on the ***RIGHT***, go down the hill and turn ***RIGHT*** at the ***STOP*** sign. The ***FIRST*** office on the ***RIGHT*** is our office.
- I-75 **NORTH** take exit 104 – Athens/Lexington. Take a ***LEFT*** onto Richmond Road.
  - Stay in ***RIGHT*** lane on Richmond Road for approximately 4.5 miles
  - Turn ***RIGHT*** at the traffic light onto North Eagle Creek Dr. (Dealership will be on the left hand side of the road.
  - Take the ***FIRST*** street on the ***LEFT***, *Eagle View Lane*. On your ***RIGHT*** you will see Central Brace and Prosthetics, on the back of that building is "Walden's Photography". We are next door to Walden's. (Take the ***FIRST*** Street on the ***RIGHT***, *Summit Square Place*. You will see the first building is 3229, take the ***FIRST DRIVE-WAY*** on the ***RIGHT***, go down the hill and turn ***RIGHT*** at the ***STOP*** sign. The ***FIRST*** office on the ***RIGHT*** is our office.

From NEW CIRCLE ROAD

- Exit New Circle Road at Richmond Road. At the end of the ramp, turn in the direction ***AWAY*** from downtown Lexington.
- Approximately 1.5 miles take a ***LEFT*** onto North Eagle Creek Drive. (This is the light after Richmond Road/Man O' War Intersection.
- Take the ***FIRST*** Street on the ***LEFT***, *Eagle View Lane*. On your ***RIGHT*** you will see
  Central Brace and Prosthetics, on the back of that building is "Walden's Photography". We are next door to Walden's. (Take the ***FIRST*** Street on the ***RIGHT***, *Summit Square Place*. You will see the first building is 3229, take the ***FIRST DRIVE-WAY*** on the ***RIGHT***, go down the hill and turn ***RIGHT*** at the ***STOP*** sign. The ***FIRST*** office on the ***RIGHT*** is our office.



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Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW IT CAREFULLY.***

Introduction

At Glen W. Simons, MD, PSC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective January 1, 2009, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Glen W. Simons, MD, PSC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Glen W. Simons, MD, PSC, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record, as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Glen W. Simons, MD, PSC, is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the physician, Dr. Glen Simons at (859) 455-8346. If you believe your privacy rights have been violated, you can file a complaint with the Office Manager or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint. The address for the Office for Civil Rights:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment

For Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the member of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment

For Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to your business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Notification: We may use of disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy or your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.