Michigan Ear Institute, P.L.L.C.

Office Use________

PATIENT INFORMATION (PLEASE PRINT)

Full Legal Name

____
First Middle Initial Last

Address ______________________________________

____

City____________________State________ Zip ______

____

Home Phone # (___) ___________________________

Cell Phone # (___) ___________________________

Emergency # (___) ___________________________

E- Mail ______________________________________

Occupation: __________________________________

Sex ☐ M ☐ F

Marital Status ☐ S ☐ M

☐ W ☐ D

Birthdate ____________________________

Soc. Sec # ___________________________

Height ____________ Weight ____________

Language: ☐ English

☐ Other:____________

Race: ☐ Caucasian

☐ African American

☐ Middle Eastern

☐ Asian

☐ Hispanic

☐ Other

Ethnicity: ☐ Hispanic

☐ Non Hispanic

NAME:______________________________ **Date of Birth:**_____/_____/_____

INSURANCE INFORMATION ***(Please bring all insurance cards to your appointment and a PICTURE ID)***

IS THIS AN ACCIDENT OR WORK RELATED INJURY? ☐ **Yes** ☐ **No**

**Primary Insurance Company:*____________________ Is this an HMO? ☐ Yes ☐ No

Subscriber's Name (if different than patient) ____________________

Relationship to patient____________________ Subscriber date of birth: __________

Subscriber SS#:____________________

Subscriber Employer:____________________ Employer Phone #: __________

**Secondary Insurance Company:*____________________ Is this an HMO? ☐ Yes ☐ No

Subscriber Name____________________

Relationship to patient____________________ Subscriber date of birth: __________

Subscriber SS#:____________________

Subscriber Employer:____________________ Employer Phone #:__________

*Tertiary Insurance Company:*____________________ Is this an HMO? ☐ Yes ☐ No

Subscriber Name____________________

Relationship to patient____________________ Subscriber date of birth: __________

Subscriber SS#:____________________

Subscriber Employer:____________________ Employer Phone #: __________

Referring Physician Name: (Please bring information)

____________________ Phone #:__________

____

____________________ Fax #:__________

Primary Care Physician - Family Doctor ***(MUST HAVE FOR HMO INSURANCE)***

____________________ Phone #:__________

____

____________________ Fax #:__________

Additional Doctors that need to be updated on your visit, please provide your information.

NAME:_______________________ **Date of Birth:**_____/_____/_____

Chief Complaint: What symptoms are you having that brings you to visit this doctor.

____

____

Describe your present problem:

EARS	**Right**	**Left**	**Duration**
Hearing loss	____	____	________
Fluctuating Hearing	____	____	________
Ear Fullness	____	____	________
Ringing/Tinnitus/	____	____	________
Buzzing	____	____	________

Have you ever worn a Hearing Aid? ☐ Yes ☐ No

Have you had a problem with ear infections? ☐ Yes ☐ No

Have you had significant noise exposure (example working with loud machines or guns such as in military exposure or hunting)? ☐ Yes ☐ No

Have you had surgery on your ears? ☐ Yes ☐ No

If Yes , what type: _______________________

Do you have dizziness? ☐ Yes ☐ No

When did it begin?______________

How long does it last? ______________

How often does it happen?______________

Is it ☐ Mild ☐ Moderate ☐ Severe

Does your dizziness affect your ability to work? ☐ Yes ☐ No

Does your dizziness affect your ability to drive? ☐ Yes ☐ No

Describe your dizziness: Check appropriate boxes

☐ Spinning/Vertigo ☐ Lightheadness ☐ Off Balance ☐ Positional

Is it associated with ☐ Headache or ☐ Nausea

Have you ever been diagnosed with Migraine headaches? ☐ Yes ☐ No

Do you have problems with: (Check box if appropriate.)

☐ Numbness on the face ☐ Double Vision ☐ Blurred Vision

☐ Difficulty Swallowing ☐ Hoarseness ☐ Tongue Weakness ☐ Shoulder Weakness

NAME:____________________________________ **Date of Birth:**______/______/______

Past Medical History: Circle any of the following medical conditions that you have or have had:

- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Irregular Heart Beat
- ☐ Sleep Apnea or CPAP
- ☐ HIV/AIDS
- ☐ Heart Attack
- ☐ Emphysema/ COPD
- ☐ Ulcer, Reflux or GERD
- ☐ Pacemaker
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ High Cholesterol
- ☐ Prostate enlargement BPH
- ☐ Depression or Anxiety
- ☐ Stroke
- ☐ Diabetes
- ☐ Dialysis or Renal Failure
- ☐ Cancer – Type ______________
- ☐ Fibromyalgia
- ☐ Seizures or Convulsions
- ☐ TMJ

Other: ____

Have you had any previous serious injury? Please describe:

____

____

____

Have you had any surgeries other than ear surgery?

____

____

____

NAME: ______________________________ **Date of Birth:** _____/_____/_____

Medications: List below the medications you are taking. Please include prescription and over the counter medications such as aspirin, cold medicines or antihistamines . (If possible bring your meds with you or a current list.)

Medication:	Dose	How Often	Why do you take this?

Do you take Vitamins and Supplements? ☐ Yes ☐ No PLEASE DO NOT LIST

Allergies: Are you allergic to any medications? ☐ Yes ☐ No
If so, please list and check the reaction you experience:

Medication:	Breathing Difficulty	Rash	Other (nausea)
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Are you allergic to latex? ☐ Yes ☐ No

Please list your pharmacy: Name: ______________________________

Phone: ______________________________

Address: ______________________________

Crossroads: ______________________________

MAIL ORDER: ☐ Medco ☐ Caremark ☐ Express Scripts, Inc

☐ Pharmacare ☐ Other

NAME:______________________________ **Date of Birth:**_____/_____/_____

Family History: What medical problems run in your family?

Father: ____________________________

Mother: ____________________________

Other : ____________________________

Social History:

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes a day? _____

Are you a former smoker? ☐ Yes ☐ No
If yes when did you quit. __________

Do you drink alcohol? ☐ Yes ☐ No
If yes how many drinks per day? ___

Have you had problems with alcoholism? ☐ Yes ☐ No

Have you had problems with drug abuse? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No

How much salt do you eat daily? For example processed food is high in salt.
☐ High ☐ Average ☐ Low

Any information related to your medical care is confidential and will not be released without your permission. Michigan Ear Institute can give medical information related to your treatment to ____.

Relationship: ________________________

Tests results and messages may be left by phone message at ________________________.

If you need to keep additional physicians updated on your visits, please provide the information on the back. A letter will be sent to your physician(s) from your MEI physician with updates UNLESS you specify that you DO NOT want one sent.

• I, the undersigned, do acknowledge that the information stated above is true. I authorize the Michigan Ear Institute to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to the Michigan Ear Institute. For insurance purposes, I permit a copy of this authorization to be used in place of the original. I do hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered, or those to be rendered to me or to my dependents by the Michigan Ear Institute, regardless of my insurance coverage, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 10%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I understand that there will be a $25 charge for any returned checks. I also authorize the Michigan Ear Institute to release medical information to the above stated physicians. I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician.

SIGNATURE OF PATIENT/LEGAL GUARDIAN________________________ **DATE:**__________
Valid for one year)
Relationship to patient: ____________________________

MEI Michigan Ear Institute, P.L.L.C.

NOTICE OF PRIVACY PRACTICES SUMMARY

To our patients: This notice describes how health information about you, as a patient of Michigan Ear Institute, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice 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. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment

for your care, such as family members or 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.

3. You have the right to inspect and obtain a copy of the health information 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 Michigan Ear Institute, Medical Records, 30055 Northwestern Hwy., #101, Farmington Hills, MI 48334 or fax request to 248-865-6161.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Michigan Ear Institute, Medical Records, 30055 Northwestern Hwy., #101, Farmington Hills, MI 48334 or fax request to 248-865-6161.
   You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice via regular mail contact Michigan Ear Institute, Medical Records Department, 30055 Northwestern Hwy., #101, Farmington Hills, MI 48334 or fax request to 248-865-6161.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Michigan Ear Institute, Practice Administrator at 248-865-4444. You will not be penalized for filing a complaint. After contacting Michigan Ear Institute you will be asked to submit your complaint in writing.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy practices, please contact our administrator or clinical manager at 248-865-4444.

I hereby acknowledge that I have been presented with a copy of Michigan Ear Institutes' Notice of Privacy Practices on Pages 10-11.

PRINT NAME OF PATIENT: ______________________________

PATIENT SIGNATURE: ______________________________

DATE: ________________

MEI PATIENT REPRESENTATIVE: ______________________________

I authorize the Michigan Ear Institute to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to the Michigan Ear Institute. For insurance purposes, I permit a copy of this authorization to be used in place of the original. I do hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered, or those to be rendered to me or to my dependents by the Michigan Ear Institute, regardless of my insurance coverage, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 10% or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I understand that there will be a $25 charge for any returned checks. I also authorize the Michigan Ear Institute to release medical information to any physician I have listed. I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician. I authorize Michigan Ear Institute to obtain medication history from electronic vendor.

For Research Purposes: We may use or disclose your protected health information for research when the use of disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

SIGNATURE OF PATIENT / LEGAL GUARDIAN:________________________________

PRINT NAME OF PATIENT: ____

DOB:________________________

DATE:________________________

MICHIGAN EAR INSTITUTE REPRESENTATIVE:________________________________

ST JOHN PROVIDENCE.

St. John Providence
Notice of Privacy Practices

1. **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.**
2. **WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**
We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each St. John Providence Health System facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice on our website at www.stjohnprovidence.org.
3. **HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.**
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

3.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.
We may use and disclose your PHI for the following reasons:

3.1.1. For treatment. We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.

3.1.2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

3.1.3. For health care operations. We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, and consultants who perform services on our behalf.

3.2. Other Uses and Disclosures That Do Not Require Your Authorization

3.2.1. When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.

3.2.2. For public health activities. For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

3.2.3. For health oversight activities. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

3.2.4. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

3.2.5. For research purposes. In certain circumstances, we may provide PHI in order to conduct research.

3.2.6. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

3.2.7. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

3.2.8. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

3.2.9. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.

3.2.10. Fundraising activities. We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

3.3. Uses and Disclosures to Which You Have an Opportunity to Object

3.3.1. Patient directories. We may include your name, location in this facility, general condition in our patient directory and disclose it to visitors who ask for you by name, unless you object in whole or in part. We also may include your religious affiliation (if any) in the facility directory and disclose facility directory information to clergy members, unless you object in whole or part.

3.3.2. Disclosure to family, friends, or others. We may provide your PHI to a family member, friend or other person to the extent that person is involved in your care or the payment for your health care, unless you object in whole or in part.

3.3.3. Special Legal Restrictions Frequently, Michigan law and/or Federal Regulations require explicit authorization for the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDS conditions.

3.4. All Other Uses and Disclosures Require Your Prior Written Authorization
In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

4. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

4.1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. However, if you pay in full out-of-pocket and you request that we not disclose any information to your health plan about that service, we must grant that request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make related to your treatment.

4.2. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

4.3. The Right to See and Get Copies of Your PHI. In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
If you request copies of your PHI, we will charge you a reasonable copying fee.

4.4. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures for treatment, payment and health care operation and some other purposes per the law. The list also will not include any uses or disclosures made before April 14, 2003.
We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $25 for each additional request.

4.5. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not required to be disclosed to you, or (iv) not part of your medical record. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

4.6. Notice by E-Mail. If you agree to receive this notice via e-mail, you still have the right to request a paper copy of this notice.

4.7. Psychotherapy Notes. We must obtain your written authorization before we may use or disclose your psychotherapy notes, except for: use by the originator of the psychotherapy notes for treatment; use or disclosure by Covered Entity for its own mental health training programs; or use or disclosure by Covered Entity to defend itself in a legal action or other proceeding brought by the individual.

4.8. Marketing. We must obtain your written authorization before we may use or disclose your PHI for marketing purposes, except for face-to face communications made by us to you or a promotional gift of nominal value provided by us to you.

4.9. Sale of PHI. We must obtain your written authorization before we sell your PHI.

4.10. Breach of PHI. We are required to notify you in the event of a breach of your unsecured PHI.

5. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: **St. John Providence Health HIPAA Privacy Office** - (See section 7 of this Notice.)
You also may send a written complaint to: Secretary of the Department of Health and Human Services
We will take no retaliatory action against you if you file a complaint.

6. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments, units and joint ventures of the following entities:

Brighton Center for Recovery
Eastwood Clinics
Medical Resources Group
Providence Hospital and Medical Centers
Providence Park Hospital
St. John Hospital and Medical Center
St. John Macomb-Oakland Hospital
St. John River District Hospital
Providence Health Foundation, Inc
St. John Providence Health Foundation
St. John Providence Health Occupational Health Partners
St. John Providence Health System
St. John Providence Health Partners
St. John Providence Physician Network
St. John Providence Community Health Investment Corp.
Affiliated Health Services, Inc
Reverence Home Health & Hospice
Ascension Physician Services
Beecher Ballenger Services
Bone & Joint Surgery Center of Novi
Cardiology Associates of Michigan
Cardiology Associates of Pt. Huron
Cardiovascular Therapeutics Management, LLC
Diagnostic Radiology Consultants
Eastpointe Radiologists, PC
Eastside Associates/Eastside Endoscopy
Emergency Medicine Specialists, PC
Great Lakes Physiatrists, PC
Independent Emergency Physicians, PC
Lakeshore ENT
Lakeshore Sleep Diagnostics
Langston, Walker & Associates
Meemac Associates, PC
Michigan Diagnostic Pathologists, PC
Michigan Ear Institute
Michigan Institute for Sleep Medicine/ Cardiopulmonary Services
Michigan Pain Management Consultants, PC
Newland Medical Associates, PC
Northland Anesthesia Associates, PC
Novi Pediatric Associates, PC
Open MRI of Michigan LLC
Partners in Care
Pathology Specialists of SE Michigan, PC
PMHC Cancer Center
Radiation Oncology Specialists, PC
St. John Anesthesiologists, PC
Southfield Radiology Associates, PC
Vinay Malviya, MD, PC
X-Ray Associates of Pt. Huron

Also, these entities, sites and locations may share medical information with physicians and other healthcare professionals within St. John Providence Health System and as a Member of a Regional Health Information Organization ("RHIO") or other Health Information Exchange ("HIE"). If you want to "opt out" of the RHIO or HIE, please notify the Privacy Officer listed under Section 7.

7. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the HIPAA Privacy Officer at 248-849-5302. All complaints must be submitted in writing to:

St. John Providence - HIPAA Privacy Officer
28000 Dequindre Road
Warren, MI 48092

8. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003. REVISED: August 6, 2013