WELCOME TO ARCH PHYSICAL THERAPY

We are happy you have chosen us to be your physical therapy provider! We hope you will find your experience at ARCH to be far above your expectations. Each therapist has over 20 years of experience in orthopedics and manual therapy and an excellent record of providing results with their patients.

A few things to keep in mind that will make your therapy experience go smoothly:

- Please arrive at your scheduled appointment time. We spend 1 on 1 time with every patient and timeliness is essential for you to receive your treatment and others to receive theirs.

- Please call if you are going to be more than 15 minutes late for your appointment.

- It is important that you keep ALL your scheduled appointments. Physical therapy is your "physical medicine" and it is important to attend all your sessions to get the best results for long term success.

- Please make your co-pay before each treatment. As a courtesy to you, we verify all insurances before your first appointment to advise you of any possible out of pocket expenses. It is ultimately the patient's responsibility to know their insurance coverage. Payment arrangements can be made in advance for patients that qualify.

- Failure to show for 3 appointments will result in your discharge from physical therapy. Excessive cancellations (more than one a week) may result in your discharge from physical therapy. Kindly give no less than 24 hours notice of any cancellations to avoid a $25 cancellation fee. You may leave a message if canceling after normal business hours. We will make every attempt to reschedule that appointment.

- Notify your therapist if there are any changes in your health or insurance.

Thank you for choosing ARCH Physical Therapy and Sports Medicine. If you have any questions, concerns or feedback, please do not hesitate to let us know.

______________________________________ ____________________

Patient Signature Date

CANCELLATION/NO SHOW FEE POLICY

(For Non-Medicare Patients)

You play an integral role in the success of your treatment. Your therapist will establish an individual treatment plan for you, including recommendations for frequency and number of treatment visits. Your dedication to attending the recommended number of treatments is vital to ensure progress with your therapy program.

We expect you to keep all of your appointments. However, we understand there may be circumstances in which you may need to cancel or reschedule an appointment.

PLEASE PROVIDE AT LEAST 24 HOURS NOTICE FOR CANCELLATIONS OR FOR RESCHEDULING AN APPOINTMENT.

- APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE WILL RESULT IN A CANCELLATION FEE CHARGED TO THE PATIENT.
- CANCELLATION FEES MUST BE PAID AT THE NEXT SCHEDULED APPOINTMENT BEFORE TREATMENT BY THE THERAPIST.
- PATIENTS ARE RESPONSIBLE FOR PAYING CANCELLATION FEES.

I HAVE READ AND FULLY UNDERSTAND THE “CANCELLATION/NO SHOW FEE POLICY” STATED ABOVE, AND I AGREE TO ADHERE TO SUCH POLICY.

_______________________________________ ____________________

Patient Signature Date

____

Patient Printed Name

Medical History Form

Patient Name:	Today's Date:	
Referring Physician:	Date of Birth:	Age:
Primary Care Physician:	Date of Injury or Onset:	
Date of Next Physician Appointment:		

Reason for Therapy:

Cause of Injury or Onset: ☐ Accident ☐ Auto ☐ Work ☐ Other: **If Other, please explain**:

Have you been hospitalized for the present condition? ☐ Yes ☐ No **If Yes, date**:

Did you have surgery for this condition? ☐ Yes ☐ No **If Yes, date**:
If Yes, surgery type:

Are you currently receiving any other care for the condition mentioned above? ☐Yes ☐No
If Yes, please describe:

Have you ever received therapy in the past for the condition mentioned above? ☐Yes ☐ No **If Yes, date:**
Describe previous treatment:

Previous Treatment: ☐Successful ☐Unsuccessful

Have you fallen in the last year? ☐ Yes ☐ No **If Yes, how many times?** **If Yes, were you injured?** ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No **Do you worry about falling?** ☐ Yes ☐ No

What are your personal goals/outcomes you hope to achieve from therapy?

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor | **Do you smoke or use tobacco?** ☐ Yes ☐ No

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ Allergies ☐ Latex ☐ Other	☐ Dizziness	☐ Kidney Problems
☐ Anemia	☐ Epilepsy or Seizure Disorder	☐ Metal Implants
☐ Anxiety or Panic Disorders	☐ Fainting	☐ MRSA
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weakness	☐ Multiple Sclerosis
☐ Asthma	☐ Fever or Chills	☐ Nausea / Vomiting
☐ Use of Blood Thinners	☐ Fractures	☐ Osteoporosis
☐ Bowel or Bladder Disorder	☐ Headaches	☐ Pacemaker
☐ Bleeding Disorder	☐ Head Injury or Concussion	☐ Parkinson's Disease
☐ Cancer	☐ Hearing Impairment	☐ Peripheral Vascular Disease
☐ Chronic Cough	☐ Heart Disease or Heart Attack	☐ Respiratory or Breathing Problems
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Ringing in Ears
☐ Congestive Heart Failure	☐ Hernia	☐ Sexual Dysfunction
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low	☐ Skin Abnormalities
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS	☐ Stroke or TIA
☐ Depression	☐ Hypoglycemia	☐ Thyroid Problems
☐ Diabetes ☐Type I ☐ Type II	☐ Hypersensitivity to Hot or Cold	☐ Tuberculosis

List any other medical problems and explain:

Medical History Form

Medication List			
Name of Medication	**Dosage**	**Frequency**	
☐ Check Box if Medication List provided separately.			
1.			☐ Injection ☐ Oral ☐ Topical ☐Other
2.			☐ Injection ☐ Oral ☐ Topical ☐Other
3.			☐ Injection ☐ Oral ☐ Topical ☐Other
4.			☐ Injection ☐ Oral ☐ Topical ☐Other
5.			☐ Injection ☐ Oral ☐ Topical ☐Other
6.			☐ Injection ☐ Oral ☐ Topical ☐Other
7.			☐ Injection ☐ Oral ☐ Topical ☐Other
8.			☐ Injection ☐ Oral ☐ Topical ☐Other
9.			☐ Injection ☐ Oral ☐ Topical ☐Other
10.			☐ Injection ☐ Oral ☐ Topical ☐Other
11.			☐ Injection ☐ Oral ☐ Topical ☐Other
12.			☐ Injection ☐ Oral ☐ Topical ☐Other

Over the Counter Medications (check all that apply): ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine: ☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

Pain Scale

Rate the severity of your pain by circling a box on the following scale.

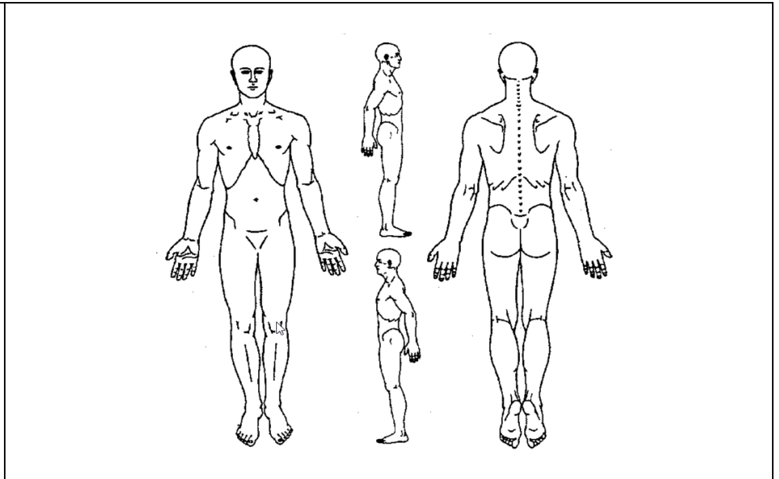
No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.

KEY:

A = Aching B = Burning N = Numbness

P = Tingling S = Stabbing O = Other



Signature of Patient:	**DOB:**
Printed Name of Patient:	**Date:**

Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total ________		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

ARCH PHYSICAL THERAPY & SPORTS MEDICINE PATIENT DATA SHEET

DO NOT EMAIL The electronic form is provided for your convenience. With respect to responding to this form, please do not send via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

____
____
____
____

Mailing Address:

____
____
____

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home: ____________	☐	____________
Work: ____________	☐	____________
Cell: ____________	☐	____________

May we send you text messages for your appointment reminders to the number(s) listed above? By marking "Yes" below, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

☐ Yes ☐ No

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: ______________________________

Preferred language: ____________________ **Interpreter required?** ☐ Yes

Date of Injury: ______________ **Referring Physician:** ______________

Injury Area: ______________ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: ______________________ **Occupation:** ______________________

Address: ____

____

Phone: ______________________

Employer: ______________________ **Occupation:** ______________________

Address: ____

____

Phone: ______________________

INSURANCE INFORMATION

Primary Insurance: ______________________

Policy Holder's Name: ______________________ **Holder's Birth Date:** ______________

Policy or Certificate #: ______________________ **Group #:** ______________

Policy Holder's Employer: ______________________

Secondary Insurance: ______________________

Policy Holder's Name: ______________________ **Holder's Birth Date:** ______________

Policy or Certificate #: ______________________ **Group #:** ______________

Policy Holder's Employer: ______________________

How did you hear about us?

- [ ] Physician
- [ ] Employer
- [ ] Case Manager
- [ ] Former Patient
- [ ] Adjustor
- [ ] School
- [ ] Hospital
- [ ] Cross Referral
- [ ] Friend - Word of Mouth
- [ ] Attorney
- [ ] Self
- [ ] Screens - Open Houses
- [ ] Marketing Ad - Print
- [ ] Marketing Ad - TV
- [ ] Marketing Ad - Billboard
- [ ] Marketing Ad - Direct Mail - Email
- [ ] Marketing Ad - Facebook
- [ ] Marketing Ad - Other ________________

Specify if other : ____________________________________

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

____________________________________ ____________________________
Name Relationship

____________________________________ ____________________________
Name Relationship

____ ____________
Signature of Patient **Date**

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
ARCH PHYSICAL THERAPY & SPORTS MEDICINE
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**___________

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:**___________

LIABILITY

I know and agree that: ARCH PHYSICAL THERAPY & SPORTS MEDICINE is not responsible for loss or damage to personal valuables. **Initials:**___________

WAIVER AND RELEASE

I hereby release, discharge and acquit: ARCH PHYSICAL THERAPY & SPORTS MEDICINE its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency physician or urgent care services. Medical Technician, **Initials:**___________

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: ARCH PHYSICAL THERAPY & SPORTS MEDICINE
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:**___________

FINANCIAL POLICY

I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf.

Initials:___________

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials:**___________
I acknowledge receipt of the Statement of Patient Rights. **Initials:**___________

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature____________________ Witness Signature ____________________

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of ARCH PHYSICAL THERAPY & SPORTS MEDICINE . This form must be completed in its entirety and must be provided to ARCH PHYSICAL THERAPY & SPORTS MEDICINE prior to initiation of therapy services.

Attachment M6.013A

STATEMENT OF PATIENT RIGHTS

* The right to efficient & equal service regardless of race, sex, physical or mental handicap, religion, ethnic background, education, social class or economic status.

* The right of considerate, courteous & respectful care from all our staff.

* The right of complete information in terms the average patient can reasonably be expected to understand.

* The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. The right to discuss alternatives to proposed procedures.

* The right to obtain assistance in language interpretation.

* The right to know the names, titles, and professions of the staff to whom you speak and from whom you receive services or information.

* The right to refuse examination, discussion and procedures to the extent permitted by law, and to be informed of the health and legal consequences of this refusal.

* The right of access to your personal health records.

* The right of respect for your privacy.

* The right of confidentiality of your personal health records as provided by law.

* The right to expect reasonable continuity of care within the scope of services and staffing of the facility.

* The right to respect for your rights and religious options.

* The right to present complaints to the Director of our facility without fear of reprisal.

Notice of Privacy Practices

(Effective September 23, 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.

Understanding Your Health Record

A record is made each time you are treated at our Clinic. Your injuries, evaluation and test results, diagnosis, treatment, and a plan of care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This Clinic uses health information about you for treatment, to obtain payment for treatment, and to evaluate the quality of care you receive, and as well as for other administrative and operational purposes. Your health information is contained in a medical record that is the physical property of our Clinic.

Our Responsibilities

This Clinic is required by law to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This Clinic is required to abide by the terms of this notice, as currently in effect, and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This Clinic reserves the right to change its practices and effect the new provisions with respect to all health information that it maintains (including such information that this Clinic had prior to implementation of the new provision). Other than for reasons described in this notice, this Clinic agrees not to use or disclose your health information without your authorization.

Use or Disclosure of Your Health Information Without Your Authorization

This Clinic may use and disclose your health information in order to provide "Treatment", obtain "Payment" and perform our "Health Care Operations", as well as other specific reasons as detailed below:

• **Treatment** – We may use and disclose health information about you to provide you with products and services or related medical treatment or services. To this end, we may communicate with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, information related to your treatment may be shared with a health care provider, such as your physician, a pharmacist, nurse, or other person providing health services to you. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also may record actions taken by them in the course of your treatment and note how you responded to the actions.

• **Payment** – We may use and disclose health information about you to others for purposes of receiving payment for treatment and services that you receive. For example, information regarding treatment you have received may be sent to you or someone who pays on your behalf (such as a family member or a credit card company) in order for this Clinic to receive payment. The information used in this fashion may include details regarding your services that identify you and could identify your diagnosis or treatment. Although it is unlikely, if other treatment providers need medical information about your treatment in order to bill for their services, we may provide it to them.

• **Health Care Operations** – We may use and disclose health information about you for administrative and operational purposes. Risk management or quality improvement personnel may use health information about you to assess the care and outcomes in your case and others like it. The results will be used internally to continually improve the quality of care for all patients. For example, we may combine medical information about many patients to evaluate the need for new products, services, or treatments. We may disclose information to health care professionals, students, and other personnel for review and training purposes. We also may combine health information we have with other sources to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy and to allow others to use the information to study health care without learning the identity of the specific patients.

We may also use and disclose your medical information to:

- evaluate the performance of our staff and your satisfaction with our services;
- learn how to improve our facilities and services;
- determine how to continually improve the quality and effectiveness of the health care we provide; and
- conduct training programs or review competence of health care professionals.

• **Individuals Involved in Your Care or Payment for Your Care.** We may release health information about you to a family member or friend who is involved in your medical care. We also may give information about you to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status, and location. We may also disclose medical information about you to local authorities or utility companies if your home care is considered "life-supporting" and you require immediate attention in the event of an emergency or power outage.

• **Business Associates** – Our "Business Associates" are entities that provide services for us and that require access to certain information in order to provide those services. We provide some services, for instance, through contracts with business associates, including companies that receive phone calls from patients when our offices are closed and companies that store patient files for us. In addition, we also contract with accountants, consultants, and attorneys to provide us with services. When such services are contracted, we may disclose health information about you to our business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associate to appropriately safeguard health information about you in a written agreement.

• **Reminders** – We may use health information about you to provide you with reminders about appointments.

• **Alternative Treatments** -We may use health information about you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you.

• Future Communications – We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which we are participating.

• **Required by Law** – We may use and disclose health information about you as required by federal, state, or local law. For example, we may disclose health information for the following purposes:

- for judicial administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

• **Public Health** – We may use or disclose health information about you for public health activities, such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

• **Food and Drug Administration (FDA)** – We may use or disclose health information for purposes of notifying the FDA of adverse events with respect to medication and product defects or post marketing surveillance information to enable product recalls, repairs, or replacements.

• **Health and Safety** – We may use or disclose health information about you to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

• **Government Functions** – We may use or disclose health information about you for specialized government functions, such as protection of public officials, national security and intelligence activities, or reporting to various branches of the armed services.

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• Medical Examiners and Others – We may use or disclose health information about you to medical examiners, coroners, or funeral directors to allow them to perform their lawful duties. If you are an organ or tissue donor, we may use or disclose health information about you to organizations that help with organ, eye, and tissue donation and transplantation.

• Workers Compensation – We may use or disclose health information about you to comply with laws and regulations related to workers compensation.

• Research – We may use or disclose health information about you for research purposes under certain circumstances. For example, we may disclose health information about you to a research organization if an institutional review board or privacy board has reviewed and approved the research proposal, after establishing protocols to ensure the privacy of your health information.

• Information Not Personally Identifiable – We may use or disclose health information about you in ways that do not personally identify you or reveal who you are.

• Law Enforcement – We may disclose your health information to the police or other law enforcement officials as required or permitted under state law or in response to a valid court order or a grand jury or administrative subpoena.

• Health Oversight Activities – We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with rules of governmental health programs, such as Medicare or Medicaid.

• Victims of Abuse, Neglect or Domestic Violence – If this Clinic reasonably believes you are a victim of abuse, neglect or domestic violence, we may disclose your health information to the appropriate governmental authority, authorized by law to receive reports of such abuse, neglect or domestic violence.

• Judicial and Administrative Proceedings – This Clinic may disclose your health information in the course of a judicial proceeding in response to a legal order or other lawful purpose.

Use or Disclosure of Your Health Information <u>With</u> Your Authorization

Other uses and disclosures not described in this Notice will be made only with the individual's written authorization. You may revoke (take back) an authorization that you had previously provided by giving us written notice. In that case, we will cease using or disclosing your information for the purpose that you had authorized. The following are some examples of uses or disclosures that require your authorization:

• Psychotherapy Notes. We do not typically maintain psychotherapy notes on any of our patients. However, if we wanted to use or disclose any psychotherapy notes we had in our possession (for instance, as part of your medical record), we would have to ask for you authorization to do so, unless the use or disclosure was to undertake certain treatment, payment, or health care operation activities as described above.

• Marketing. We must obtain your authorization before we use or disclose your health information for marketing purposes, unless that marketing relates to certain treatments you are already undergoing (or available alternatives), the marketing is conducted face-to-face, or the marketing involves a promotional gift of nominal value.

• Sale of Health Information. This Clinic will not sell your health information to third parties for marketing purposes.

Your Health Information Rights

You have the following rights with respect to health information about you. To exercise any of your rights, please see the contact information at the end of this notice.

• Right to Inspect and Copy You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. You have the right to an electronic copy of your health information if it is maintained electronically. Your request must be in writing. If you request a copy of your health information, we may charge you a fee to cover the costs of copying and mailing the information. If you request a copy of your information electronically on a portable electronic media device (such as a CD or USB drive), we may charge you for the cost of that media device.

In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your health information, we will explain our reasons in writing. You have the right to request that the decision be reviewed by another person. We will comply with the outcome of the review.

• Right to Amend If you feel that health information about you that we maintain in certain groups of records is inaccurate or incomplete, you have the right to request that we amend the information. You have the right to request an amendment as long as we maintain the information. Your request must be in writing and include a reason supporting the request.

In certain circumstances, we may deny your request to amend your health information. If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records.

• Right to an Accounting of Disclosures You have the right to request an accounting or detailed listing of certain disclosures of your health information. The time period covered by the accounting is limited. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

• General Right to Request Restriction You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. Please be aware that we are not required to agree to your request for restrictions. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment.

• Right to Restrict Disclosure to a Health Plan You have the right to request that we not disclose the portion of your health information developed during a treatment that you (or someone else) paid for entirely out-of-pocket to your health plan. This request must be in writing. We may not refuse this request.

• Right to Request Alternative Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternative address for delivery or communication purposes.

• Right to Revoke Authorization There are occasions when you may give us written authorization to use or disclose your health information. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization.

• Right to be Notified of a Breach In the event some portion of your health information is lost, stolen, or otherwise improperly accessed, you have the right to be informed. You will be informed in writing, unless you have previously established a preference for electronic communications.

• Right to Copy of Notice of Privacy Practices You have the right to a paper copy of our Notice of Privacy Practices at any time. To obtain a copy of our current Notice of Privacy Practices, please ask the front office staff at this clinic.

Complaints

If you believe your privacy rights have been violated, you may complain to this Clinic, the Privacy Officer, and/or to the Secretary of the U. S. Department of Health and Human Services. You may make a complaint via the contact information at the end of this notice. You will not be retaliated against for filing a complaint.

Contact Information

If you have any questions, wish to obtain copies of your health information, amend, request an accounting, or exercise any other rights identified in this notice, or would like to file or discuss a complaint regarding our privacy practices, please contact this Clinic.

To Receive Additional Information or Report a Problem

For further explanation of this notice you may contact our **Privacy Officer at 1-800-580-6285**. If you believe your privacy rights have been violated, you have the right to file a complaint with our Privacy Officer or with the United States **Secretary of Health and Human Services** at **1-800-368-1019** with no fear of retaliation by this Clinic.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posted where registration occurs. **All individuals receiving care will be provided a hard copy upon request and asked to acknowledge receipt.**

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