CONFIDENTIAL PATIENT CASE HISTORY

WELCOME GILBERT PHYSICAL MEDICINE!
Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

PERSONAL INFORMATION

Name:______________________________ Date:____________

Date of Birth:____/____/____ Age:________ Sex: ❑ Male ❑ Female Marital Status: S / M / D / W

Address:____________________ City:____________ State:_____ Zip:________

Social Security #:________-______-________ Home Phone:(______) ________-__________

Cell Phone:(______)________-__________ E-mail:______________________

Occupation:____________________ Employer:____________________

Employer Address:____________________ Work Phone:(______)________-__________

Spouse's Name:____________________ Date of Birth:____________ Age:______

Employer Address:____________________ Work Phone:(______)________-__________

Social Security #:________-______-________ How Many Children (Ages)?:____________

Emergency Contact:____________________ Phone:(______) ________-__________

Who Referred You To Us?:______________________________

How Else Did You Hear About Us?:______________________________

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom?:______________________________

How long have you had this condition?:______________________________

Have you had this or similar conditions in the past?:______________________________

What do you think caused this condition?:______________________________

What position(s), if any, make it feel worse?:______________________________

What position(s), if any, make it feel better?:______________________________

Over time, is this condition: ❑ Improving ❑ Unchanged ❑ Getting Worse?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine Other:____________

Have you sought advice or treatment from other doctors or therapists for *this* condition? ❑ Yes ❑ No

If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

____________________ ____________ ____________________
Name Date of visit Diagnosis

____________________ ____________ ____________________
Name Date of visit Diagnosis

Describe any treatment you have had for *this* condition (include medication dosage and frequency)?:__________

____

____

Family Medical Doctor:____________ Address:____________ Date of Last Physical:________

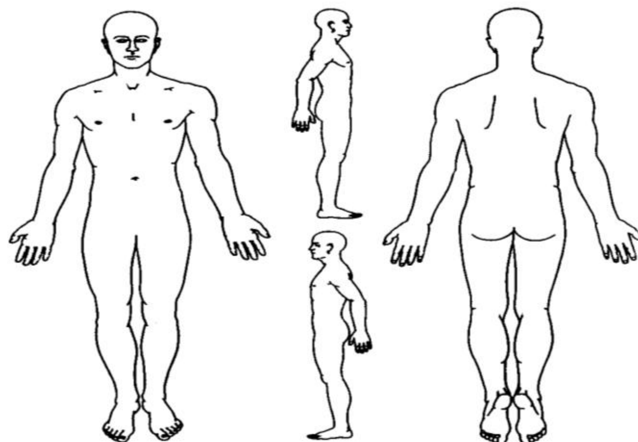
May we communicate our findings on your current health condition to the above provider(s)? ❑ Yes ❑ No

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:____ Date:__________________

OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.



Primary Complaint:

1) ______________________ 1 2 3 4 5 6 7 8 9 10

Additional Complaints:

2) ______________________ 1 2 3 4 5 6 7 8 9 10
3) ______________________ 1 2 3 4 5 6 7 8 9 10
4) ______________________ 1 2 3 4 5 6 7 8 9 10
5) ______________________ 1 2 3 4 5 6 7 8 9 10

PREVIOUS CONDITIONS

Days Lost From Work:_____________ Date of Last Physical Examination: __________________________

Have you sought care for another health condition in the past year? ❑ Yes ❑ No Past 2 years? ❑ Yes ❑ No

If yes, what condition other than your primary complaint?:____

Was treatment administered? ❑ Yes ❑ No Describe: ____

____

Do you take medications? ❑ Yes ❑ No List Dosage, Frequency and Reason:__________________________

____

____

Any prior hospitalizations or surgery? ❑ Yes ❑ No Describe with dates:______________________________

____

Have you been in an auto accident or had any other personal injury? ❑ Yes ❑ No Describe:_______________

____

CHIROPRACTIC HISTORY

Previous Chiropractic care? ❑ Yes ❑ No If yes, Doctor's name:______________________________________

Date of last chiropractic visit: ______/______/______ Date of last chiropractic X-rays:______/______/______

Reason for care:______________________________ How long were you under care?: _______________

Were you satisfied with the previous chiropractic care you received? ❑ Yes ❑ No

Are other family members under chiropractic care? ❑ Yes ❑ No Who?: ___________________________

Are you open to looking at new ideas in health and wellness? ❑ Yes ❑ No

SOCIAL HISTORY

Height:_____ft. _____in. Current Weight:_________ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:__________

Physical Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:__________

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per week:__________ Type:__________________

Smoking: ❑ Never ❑ Currently ❑ Previously Packs/day:_____, Pack/week:______ How long?:_____

Alcohol: Beer/week:_______, Liquor/week:_______, Wine/week:_______ How long?:_______

Caffeine: Cups/day:_______ How long?:_______ Aspirin: No./day:_______ How long?:_______

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:____ Date:____________________

REVIEW OF SYSTEMS **(NOW=within the past 1 year; PAST=over one year ago)**

GENERAL	Now	Past
Weakness	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
SKIN		
Color Changes	❑	❑
Nail Changes	❑	❑
Hair Changes	❑	❑
Moles	❑	❑
Rashes	❑	❑
Sores	❑	❑
Weakness	❑	❑
HEAD & EYES		
Headaches	❑	❑
Injuries	❑	❑
Bumps	❑	❑
Last Eye Exam	❑	❑
Glasses	❑	❑
Contacts	❑	❑
Cataracts	❑	❑
EARS		
Hard of Hearing	❑	❑
Deafness	❑	❑
Ringing	❑	❑
Discharge	❑	❑
Earache	❑	❑
Itching	❑	❑
Dizziness	❑	❑
Room Spins	❑	❑
NOSE		
Decreased Smell	❑	❑
Bleeding	❑	❑
Pain	❑	❑
Discharge	❑	❑
Obstruction	❑	❑
Post Nasal Drip	❑	❑
Deviated Septum	❑	❑
Runny Nose	❑	❑
Sinus Congestion	❑	❑
MOUTH		
Bleeding Gums	❑	❑
Sores	❑	❑
Dental Problems	❑	❑
Bad Breath	❑	❑
Loss of Taste	❑	❑
Dry Mouth	❑	❑
Ulcers	❑	❑
Blisters	❑	❑
THROAT		
Soreness	❑	❑
Bad Tonsils	❑	❑
Hoarseness	❑	❑
Pain	❑	❑
Trouble Swallowing	❑	❑
Recurrent Infections	❑	❑
NECK		
Neck Enlargement	❑	❑
Stiff Neck	❑	❑
Soreness	❑	❑
Lumps	❑	❑
Masses	❑	❑

BREASTS	Now	Past
Discharge	❑	❑
Lumps	❑	❑
Pain	❑	❑
Bleeding	❑	❑
Nipple Changes	❑	❑
Skin Changes	❑	❑
Bloated	❑	❑
RESPIRATORY		
Cough	❑	❑
Phlegm	❑	❑
Blood	❑	❑
Short of Breath	❑	❑
Wheezing	❑	❑
Pain	❑	❑
Congestion	❑	❑
Inhalant exposure	❑	❑
CARDIOVASCULAR		
Murmur	❑	❑
Palpitations	❑	❑
Rapid Heartbeat	❑	❑
Swollen Extremities	❑	❑
Cold Extremities	❑	❑
Chest Pain,Pressure	❑	❑
Varicose Veins	❑	❑
Blood Clots	❑	❑
Blue Extremities	❑	❑
BLOOD		
Anemia	❑	❑
Low Blood Iron	❑	❑
Easy Bruising	❑	❑
Easy Bleeding	❑	❑
Swollen Nodes	❑	❑
Painful Nodes	❑	❑
Sugar in Blood	❑	❑
Red Spots	❑	❑
GASTROINTESTINAL		
Abdominal Pain	❑	❑
Nausea	❑	❑
Bloated	❑	❑
Belching	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Irreg. Bowel Habits	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas	❑	❑
Hemorrhoids	❑	❑
Poor Appetite	❑	❑
Food Intolerance	❑	❑
Bloody Stools	❑	❑
Black Stools	❑	❑
GENITOURINARY		
Urgency	❑	❑
Incontinence	❑	❑
Straining	❑	❑
Back Pain	❑	❑
Frequent Voiding	❑	❑
Stones	❑	❑
Burning	❑	❑
Bed Wetting	❑	❑
Small Stream	❑	❑
Discharge	❑	❑
Impotence	❑	❑

GENITOURINARY	Now	Past
Dribbling	❑	❑
Cloudy Urine	❑	❑
Spotting	❑	❑
Menstrual Cramps	❑	❑
Painful Menses	❑	❑
Itching	❑	❑
Painful Intercourse	❑	❑
Irregular Periods	❑	❑
Hot Flashes	❑	❑
NEUROLOGICAL		
Seizures	❑	❑
Vertigo	❑	❑
Dizziness	❑	❑
Hand Trembling	❑	❑
Loss of Sensation	❑	❑
Incoordination	❑	❑
Loss of Facial	❑	❑
Weak Grip	❑	❑
Paralysis	❑	❑
Difficulty Speech	❑	❑
Tingling	❑	❑
Loss of Memory	❑	❑
Numbness	❑	❑
ENDOCRINE		
Weight Loss	❑	❑
Weight Gain	❑	❑
Extremely Thin	❑	❑
Heat Intolerance	❑	❑
Cold Intolerance	❑	❑
Hair Changes	❑	❑
Breast Changes	❑	❑
IMMUNIZATION/VACCINATION		
DPT	❑	❑
Mumps	❑	❑
Smallpox	❑	❑
Typhoid	❑	❑
Tetanus	❑	❑
Measles	❑	❑
Pneumococcal	❑	❑
Influenza	❑	❑
Polio	❑	❑
MMR	❑	❑
PSYCHIATRIC		
Hyperventilation	❑	❑
Insecurity	❑	❑
Depression	❑	❑
Troubles Sleep	❑	❑
Irritable	❑	❑
Hallucinations	❑	❑
Loss of Memory	❑	❑
Alcoholism	❑	❑
Drug Addiction	❑	❑
Drug Dependent	❑	❑
Suicidal Thoughts	❑	❑
Extreme Worry	❑	❑
Sexual Problems	❑	❑
MUSCULOSKELETAL		
Muscle Pain	❑	❑
Muscle Weakness	❑	❑
Muscle Cramps	❑	❑
Muscle Stiffness	❑	❑
Joint Stiffness	❑	❑
Joint Pain	❑	❑

PAST MEDICAL HISTORY

Check only the ones you have had in the past.

Hay Fever	❑
Mumps	❑
Rheumatic Fever	❑
Allergies	❑
Angina	❑
Cancer	❑
Tumor	❑
Blood Disease	❑
Leukemia	❑
Heart Trouble	❑
Varicose Veins	❑
Phlebitis	❑
Hypertension	❑
Stroke	❑
Ulcers	❑
Jaundice	❑
Skin Trouble	❑
Gallstones	❑
Liver Trouble	❑
Hepatitis	❑
Parasites	❑
Epilepsy	❑
Paralysis	❑
Polio	❑
Mental Illness	❑
Alcoholism	❑
Depression	❑
Nervous Breakdown	❑
Migraine	❑
Gout	❑
Hemorrhoids	❑
Prostate Problems	❑
Sexual Problems	❑
Gonorrhea	❑
Syphilis	❑
Diabetes	❑
Bladder Trouble	❑
Kidney Stones	❑
Kidney Infections	❑
Dysentery	❑

ALLERGIES

List known allergies below

____
____
____
____
____
____
____

If Female,
Are You Pregnant?

❑ **Yes**
❑ **No**

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:______________________________ Date:______________

FAMILY HISTORY - List any of the diseases listed previously which run in your family

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses (if any)
Father:					
Mother:					
Brother(s):					
Sister(s):					
Grandfather (Mat):					
Grandmother (Mat):					
Grandfather (Pat):					
Grandmother (Pat):					

Spouses Health Status: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Children's ages and health status:______________________________

____

INSURANCE INFORMATION

Who is responsible for this account?: ______________________________

Relationship to Patient?: ______________ Social Security No: ______-______-______

Insurance Co.: ______________ Patient ID#: ______________ Group #: ______________

Is patient covered by additional or secondary insurance? ❑ Yes ❑ No

Subscriber's Name: ______________________________

Relationship to Patient?: ______________ Birth Date: ______________

Insurance Co.: ______________ Patient ID#: ______________ Group #: ______________

ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email and phone in regards to treatment as well as promotional activities. This clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.

SIGNATURE of Patient, Parent or Guardian: ______________________________

PRINTED Name of Patient, Parent or Guardian: ______________________________

Date: ______________ Relationship to Patient: ______________________________

Witness Signature: ______________________________ Date: ______________

(A scanned copy of this document shall serve as the original.)

Gilbert Physical Medicine

Patient Informed Consent

When a person seeks health care and we accept a patient for such care, it is essential for both parties to work towards the same objectives. It is important that each party understand both the objectives and the method(s) that will be used to accomplish the goals set forth. This document is meant to summarize services available and obtain your written consent for evaluation, testing, treatment, and/or referral.

Patient Messaging & Communications: **Initial:** ________

By supplying my phone number(s), email, and any other personal contact information, I authorize my health providers to employ third-party automated outreach and messaging to use my personal information, provider name, the time and date of scheduled appointments, and other limited information for the purpose of notifying me of pending appointments, balances, diagnostic results, or other communications. I also authorize my health care providers to disclose limited protected health information (PHI) regarding healthcare events.

Preferred Method of Contact: ☐Phone ☐Text ☐Email

Who would you like us to share information with: ☐N/A

Please List: ____

____

____

Examination, Therapies, and Chiropractic: **Initial:** ________

During the course of routine *examinations* some tests may be provocative in nature and cause exacerbations of existing conditions. X-ray exposure carries risk of radiation and cancers. Various *therapies* like electrical stimulation, mechanical muscle therapies, cold laser, and traction are intended to reduce pain, stimulate circulation, ease muscle tension/spasms, and accelerate healing time. Some of the following risks may be associated: Soreness in the area, electric shock, mild burns, bruising, or eye damage. *Chiropractic* has been proven safe and effective, however, it is not unusual to be sore especially after the first few visits. Although rare, it is possible to suffer from side effects such as muscle spasms, stiffness, rib fracture, headache, dizziness, and stroke.

Injection Therapies (Trigger points, Joints, Tendons, Ligaments): **Initial:** ________

These are local injections used to treat muscle pain, spasms, knots, and joint pain. Lidocaine is usually an ingredient added to help relieve pain. Other medications may be added such as homeopathics, enzymes, and/or corticosteroids. These injections are typically therapeutic, but are also diagnostic. The medications used can help decrease pain and restore normal function and motion. I understand and accept the most likely risks and complications of injections, which include but are not limited to: Infection, Needle Breakage, Numbness, Trauma to Nerves,

Pneumothorax/Collapsed Lung,Vasovagal Reaction (fainting), Soft Tissue Swelling, Bruising or Hematoma Formation.

Sphenopalatine Ganglion Nerve Block (SPG): **Initial: ________**
This treatment is to disrupt and break the cycle of headaches and migraines. It consists of a series of treatments to be determined by your provider to desensitize the nerve bundle associated with chronic headaches and migraines. Bupivacaine is the medication most commonly used. Inform your provider if you have a deviated septum, use any inhaled drugs, have had nasal congestion longer that 10 days, fever, or any bleeding disorders. Rare, but possible side effects include allergic reaction, nasal irritation or bleeding.

Pregnancy Release:
This is to certify that to the best of my knowledge, I am not pregnant and the provider(s) and associates have my permission to perform x-ray evaluation if clinically indicated.
I am currently: ☐**NOT PREGNANT** ☐ **PREGNANT** **Initial: ________**

Consent to Evaluate and Treat a Minor:
I, ________________________ being the parent or legal guardian of _____________________ have been explained, read, and fully understand the tests and/or treatments and hereby grant permission for my child to receive the recommended care.

Patient Policies:

I understand that there is a $25 charge for cancelled medical appointments without a 24 hour advance notice for any appointment with the Medical Doctor, Physician Assistant, or Nurse Practitioner. **Initial: ________**

I understand that the patient is ultimately responsible for full payment for their treatment and care. Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claims. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct, or updated. Patients are responsible for the payment of copays, co-insurance and deductibles and all other procedures, treatments or services not covered by their insurance plan. Patients are responsible for contacting their insurance carrier for an explanation of any service not covered. Payment is due at the time of service, and for your convenience, we accept cash, check and most major credit cards. Patients may incur, and are responsible for the payment of additional charges at the discretion of Gilbert Physical Medicine. These charges may include, but are not limited to supportive braces, vitamins, supplements, cash services, and special consultations. **Initial: ________**

Gilbert Physical Medicine

Patient Informed Consent

I understand that there is a $50 charge for forms completed by our Providers, including, but not limited to disability and FMLA forms. **Initial:** ________

I understand that there is a $35 charge for a returned check. **Initial:** ________

Disclosures: A physician must notify a patient that the physician has a direct financial interest in separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27),(I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below goods or services (I/We) have prescribed are available elsewhere on a competitive basis. Diagnostic or treatment agency or non-routine goods and services:

South Mountain Surgical Center
Broadway Surgical Center
Arizona Pain Solutions
Revitalize Health and Wellness

These services are available elsewhere on a competitive basis. Local pain centers and laboratories found on internet search or through your insurance website. I have read, understand, and agree to the provisions of the Patient Financial Responsibility and Disclosure Form.

I, (*your name here*) ____, give consent for the doctors, assistants, and clinic staff to evaluate and treat as medically necessary. I have been explained the recommended treatments, side effects, and options and do hereby consent to care. By signing I agree that I have read, understand, and initialed the above consents, policies, and disclosures.

Printed Patient Name: _____________________________________ Date: ____________

Signature of Patient: _____________________________ Witness: _______________________

HIPAA Notice of Privacy Practices

Gilbert Physical Medicine

725 W. Elliot Rd. Suite 115 Gilbert, Az. 85233

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

If you have any questions about the above notice, please contact our Office at

480-545-0000

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's
privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.
To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights
You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints
If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

____ ____________________________
Patient Signature Date