Desert Springs Chiropractic Center
127 W. Juanita Ave., Suite #110
Mesa, Arizona 85210
Office (480) 668-1199
Fax (480) 668-7300

Patient's Accident Account

Patient Name ______________________________ Employer ______________________________

Patient Address ______________________________ Employer Address ______________________________

Patient Phone No. ______________________________ Employer Phone No. ______________________________

Emergency Contact Name ______________________________ Emergency Contact Phone No. ______________________________

Date of Accident ____________________ Time ______________ AM/PM

Location of Accident or Injury ____

Type of Accident (Select one) ☐ Auto Collision ☐ Work ☐ Other ______________________________

Please describe the accident or injury (in as much detail as possible)

____

____

____

Auto Injury Questions:

Were you the (select one)	☐ Driver	☐ Passenger	☐ Pedestrian		
Were you struck from (select one)	☐ Behind	☐ Front	☐ Left Side	☐ Right Side	☐ Parked
Did your car strike others involved?		☐ Yes	☐ No		
Did the other car strick yours?		☐ Yes	☐ No		
Did you have a seat belt on?		☐ Yes	☐ No		
Did any part of your body strike the car?		☐ Yes	☐ No	Which? ______________	
Were traffic citations issued to you?		☐ Yes	☐ No		
Issued to other drivers?		☐ Yes	☐ No		
To the driver of the car you were in?		☐ Yes	☐ No		

Work Injury Questions:

Was your employer notified?	☐ Yes	☐ No
Did the employer refer you anywhere?	☐ Yes	☐ No

Please describe how you felt after the accident (in as much detail as possible).

____

____

____

Please read carefully & check any of the symptoms that you have noticed since the accident or injury.

☐ Headache	☐ Dizziness	☐ Loss of Memory	☐ Ringing in Ears
☐ Neck Pain	☐ Head Seems Heavy	☐ Face Flushed	☐ Los of Balance
☐ Neck Stiff	☐ Pins & Needles in Arms	☐ Pins & Needles in Legs	☐ Fainting
☐ Sleeping Problems	☐ Numbness in Fingers	☐ Numbness in Toes	☐ Constipation
☐ Back Pain	☐ Shortness of Breath	☐ Upset Stomach	☐ Diarrhea
☐ Nervousness	☐ Light Bother Eyes	☐ Tension	☐ Cold Sweats
☐ Irritability	☐ Buzzing in Ears	☐ Depression	☐ ______________
☐ Chest Pain	☐ Cold Hands	☐ Lightheadedness	☐ ______________

Do you feel any popping, tearing or ripping in your neck or back? ☐ Yes ☐ No

Did you have any bruises? ☐ Yes ☐ No ☐ Where? ______________________________

Have you ever been treated before for any of these symptoms? ☐ Yes ☐ No

Did you go to the Emergency Room?	☐ Yes	☐ No	Where? ______________________________
Were you examined?	☐ Yes	☐ No	
Were you X-Rayed?	☐ Yes	☐ No	
Was there treatment given?	☐ Yes	☐ No	
Medication?	☐ Yes	☐ No	

Have you seen other doctors? ☐ Yes ☐ No ☐ Who?

____

Have you lost any days from work? ☐ Yes No ☐ How many? ______________

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Personal Injury Insurance Information

Today's Date: ______________________________ Accident Date: ____________________________________

Name: ____ ☐ Driver ☐ Passenger

Please provide as much information as possible so that your case can be set up to your financial advantage. In the state of Arizona Insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment may occur. We only need to be paid once. so all overpayments will be reimbursed to you at the time you are released from care.

Primary Insurance: (Health Insurance that covers you)

Insured Name: ____

Insurance Name: ____

ID#: _____________________________________ Group ____

Insurance Phone # __________________________

Medical Payment Coverage: (One your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be coverage called "Medpay". This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or wasn't your fault, to slamming your finger in your car door. **Using this portion of the policy cannot raise your premium or effect your records in any way**. In fact, this is exactly why you pay for "Medpay" on your insurance policy).

Claimant: ____

Policy Holder's Name: ____

Insurance Name: ____ Phone #: ___________________________

Policy #: ____ Claim #: ___________________________

Adjuster's Name: ____ Phone #: ___________________________

Policy Verification by CA: ____

____

Third Party Liability: This is the insurance information for the person who was in the "other car". The information can be found on the Accident Report.

Driver's Name: ____

Policy Holder's Name ____

Insurance Name: ___________________________________ Insurance Phone: ___________________________

Policy #: ____ Claim #: __________________________________

Adjuster's Name: ___________________________________ Phone#: __________________________________

Policy Verification by CA: ____

____

Attorney Information:

Name: ____ Phone#: ___________________________________

Desert Springs Chiropractic Center

127 W. Juanita Ave, #110 Mesa, AZ 85210
(480) 668-1199/ Fax (480) 668-7300

Name ______________________________ Address ______________________________
City ______________________ State __________ Zip ____________ Home ph# ____________________
Cell# (For confirming apt.): ____________________ E-mail Address : ______________________________
SSN _______/_______/_______ Date of birth _____/_____/_____ Age _______ Height __________ Weight __________
Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ # of children _______ Spouse's name ______________________
Employer ______________________________ Address ______________________________
City ____________________ State _____ Zip ________ Wk ph: ______________ Occupation ______________

What is the name of your family physician? ________________ What city are they located in ____________________
Have you ever had Chiropractic care before? _____ If yes, doctor name: ______________ Date of last visit ____________
If you are experiencing any pain (neck pain, low back pain, etc.), health problems, symptoms, and/or complaints, <u>please list in order of severity</u>
1. ______________________________ For how long? ____________________
2. ______________________________ For how long? ____________________
3. ______________________________ For how long? ____________________
4. ______________________________ For how long? ____________________
Has this problem been getting worse ☐ staying the same ☐ ? Currently or in the past have you ever experienced any of these complaints while working? ______ If yes, please describe what activities at work may be causing you these complaints: ____________________
Are there any other activities, incidents, or events outside of work that may have caused these complaints? ____________________
____
If yes, please explain: ____
Have you at any time in the past ever suffered a work injury? __________ If yes, what is the date of injury? _____/_____/_____
Do you have an attorney representing you for this work injury? yes ☐ no ☐ If yes, who is your attorney? ____________________
Have you been involved in an auto accident in the last 12 months? yes ☐ no ☐ If yes, what is the date of injury? _____/_____/_____
Do you have an attorney representing you for this auto injury? yes ☐ no ☐ If yes, who is your attorney? ____________________
How many other passengers were in the car with you? ______________________________
List other doctors consulted for these conditions? 1) ____________________ 2) ____________________
If due to an auto accident, what is the name of your auto insurance company? ______________________________

Have you ever had any surgeries or hospitalizations? _______ If yes, please list: ______________________________
Please list any current or past injuries and illnesses not listed above: ______________________________
Please check all medications (over the counter and/or prescribed) you are currently taking: NSAID/Aspirin/Tylenol ☐ Pain killers ☐ Muscle Relaxer ☐
Insulin ☐ Birth Control Pills ☐ Sleeping Pills ☐ Anti-depressants ☐ Others ______________________________

Health Insurance Co. Name ______________________________ Policyholder ____________________
Name of Spouse's health insurance (If applicable) ____________________ Policyholder ____________________
Spouse's Health Insurance Claims address ____________________ Policy number ____________________

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. **Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.**

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.
0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

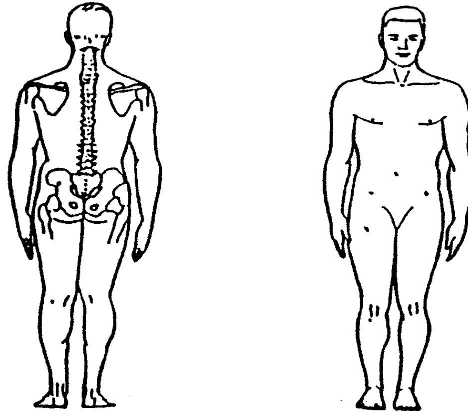
Completely able to function — **Totally unable to function**

RATE:

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc) ____________
2. RECREATION: hobbies, sports, and other similar leisure time activies. ____________
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. ____________
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. ____________
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) ____________
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. ____________

If you are experiencing any health problems, please **mark the exact location of your pain on the diagram below**. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: ☐CASH ☐ CHECK ☐ CREDIT CARD ☐ ________________________________

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. The film itself is the property of this office. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature ____ Date____________________________

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ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Prolonged Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Prolonged Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _______________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
______________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient signature: ____

Printed Name: ____

Today's Date: ______/______/______

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Patient Name:____ **Date:**_____/_____/_____

Please mark **P** for in the **Past, C** for **Currently** have, or **Leave Blank** if **Never**

___ Headache
___ Neck Pain
___ Jaw Pain, TMJ
___ Shoulder Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Hip Pain
___ Back Curvature
___ Scoliosis
___ Numb/Tingling arms, hands, fingers
___ Numb/Tingling legs, feet, toes

___ Pregnant (Now)
___ Frequent Colds/Flu
___ Convulsions/Epilepsy
___ Tremors
___ Chest Pain
___ Pain w/Cough/Sneeze
___ Foot or Knee Problem
___ Sinus/Allergy Problem
___ Swollen/Painful Joints
___ Skin Problems

___ Dizziness
___ Loss of Balance
___ Fainting
___ Double Vision
___ Blurred Vision
___ Ringing in Ears
___ Hearing Loss
___ Depression
___ Irritable
___ Mood Changes
___ ADD/ADHD

___ Prostate Problems
___ Erectile/Sexual Dysfunction
___ Digestive Problems
___ Colon Trouble
___ Diarrhea/Constipation
___ Menopausal Problems
___ Menstrual Problem
___ PMS
___ Bed Wetting
___ Gall Bladder Trouble
___ Eating Disorder

___ Ulcers
___ Heartburn
___ Heart Problem
___ High Blood Pressure
___ Low Blood Pressure
___ Asthma
___ Difficulty Breathing
___ Lung Problems
___ Kidney Trouble
___ Trouble Sleeping
___ Liver Trouble

Family History

☐ Cancer: ☐ Sibling ☐ Mother ☐ Father ☐ Grandfather ☐ Grandmother

☐ Osteoporosis / Osteopenia / Decreased Bone Mass

☐ Degenerative Disc Disease / Spinal Arthritis / Spinal Stenosis

☐ Previous Spinal / Neck Surgery (explain) ____

☐ Diabetes ☐ Stroke / TIA ☐ Genetic Disorders (explain)_________________________

Social History

☐ Alcohol ☐ Tobacco / Smoking ☐ Recreational Drugs ☐ Medical Marijuana

Medications

☐ Birth Control ☐ Blood Thinner (Coumadin, etc.) ☐ NSAID ☐ Narcotic Pain Medication ☐ Muscle relaxers

☐ Fluoroquinolones antibiotics (examples: Cipro, Factive, Levaquin, Avelox, Noroxin, floxin medications)

☐ Statin Drugs (example: Lipitor, atorvastatin, Pravochol, Crestor, Zocor, Lescol, Vytorin, simvastatin, etc.)

Desert Springs Chiropractic Center

Patient Name: ____ **Date:** _____/_____/______

Symptom Intake Form

Symptom 1 ______________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________________
  - Did the symptom begin ***suddenly*** or ***gradually*** ? (circle one)
  - How did the symptom begin? ______________________________________
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ______________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 ______________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________________
  - Did the symptom begin ***suddenly*** or ***gradually*** ? (circle one)
  - How did the symptom begin? ______________________________________
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ______________________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Desert Springs Chiropractic Center

Patient Name: ______________________________ **Date:** ____/____/_____

Symptom 3 ______________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________
  - Did the symptom begin ***suddenly*** or ***gradually*** ? (circle one)
  - How did the symptom begin? ______________________________
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ______________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 ______________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
- 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ______________________________
  - Did the symptom begin ***suddenly*** or ***gradually*** ? (circle one)
  - How did the symptom begin? ______________________________
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ______________________________
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ______________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

HIPAA Notice of Privacy Practices

Desert Springs Chiropractic Center
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Mesa, AZ 85210
(480) 668-1199 / F (480) 668-7300

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.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and/or others outside our office that are involved in your care and/or treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician, imaging center, etc. to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff or medical students, licensing, and conducting or arranging for other business activities. This office utilizes and "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting and exercise area at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, providing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting. There are various interpretations under federal law with respect to what is known as "incidental disclosure" of health information. It is our view that the kinds of matters related in an "open door" environment are incidental matters. In the event you need to discuss a private matter with our physician or staff you can request a private area for consultation.

We may publish patient testimonials, contest winners, office-related activities or photographs taken in the office in such things as newsletters, handouts, websites, advertising, social media or other marketing. If you choose not to authorize this information, your decision will have no adverse effect on your care at our facility or your relationship with our staff. If you choose not to provide us with authorization, please notify us in writing.

We may use or disclose your PHI in the following situations without your authorization. These situations include: Food and Drug Administration requirement, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donations, Research, Criminal Activity Investigation, Military Activity and National Security, Worker's Compensation, regarding Inmates, Required Use and Disclosure, Under the law, we must make a disclosure to you if and when required by the Secretary of the Dept. of Health and Human Services to investigate or determine our compliance with requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures will be made with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure in the authorization.

YOUR RIGHTS
The following is a statement to your rights with respect to your protected health information (PHI).

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be specific restriction requested and to whom you want the restriction to apply in writing.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use disclosure of your PHI, your PHI will not be restricted. You have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon, request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.

We have the right to change the terms of this notice, and the changes will be applied to all information we have about you. The new notice will be available upon request, in our office and on our website. You have the right to object or withdraw as provided in this notice.

Complaints
You can complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **November 25, 2019.**

Please list the names of anyone we would be allowed to discuss your protected medical information (PHI).

Name:________________________________ Ph#:__________________ Relationship:_______________

Name:________________________________ Ph#:__________________ Relationship:_______________

Name:________________________________ Ph#:__________________ Relationship:_______________

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by telephone at our main phone number (480) 668-1199.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices.

____ ________________________
Patient or Legally Authorized Individual Signature Date

____ ________________________
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)