

PATIENT DATA SHEET

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

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

Physical Address: _____ **Mailing Address:** _____

Phone Numbers:	OK To Call	Best Time To Call
Home: _____	<input type="checkbox"/>	_____
Work: _____	<input type="checkbox"/>	_____
Cell: _____	<input type="checkbox"/>	_____

Preferred language: _____ **Interpreter required?** Yes

Date of Injury: _____ **Referring Physician:** _____
Injury Area: _____ **Auto or Work Accident:** Auto Work N/A
State Where Accident Occured: _____
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

How did you hear about us?

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Marketing Ad - Print |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Cross Referral | <input type="checkbox"/> Marketing Ad - TV |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Friend - Word of Mouth | <input type="checkbox"/> Marketing Ad - Billboard |
| <input type="checkbox"/> Former Patient | <input type="checkbox"/> Attorney | <input type="checkbox"/> Marketing Ad - Direct Mail - Email |
| <input type="checkbox"/> Adjustor | <input type="checkbox"/> Self | <input type="checkbox"/> Marketing Ad - Facebook |
| <input type="checkbox"/> School | <input type="checkbox"/> Screens - Open Houses | <input type="checkbox"/> 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

EMPLOYMENT STATUS

Employment Status:

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

PATIENT EMPLOYER INFORMATION

Employer: _____ **Occupation:** _____

Address: _____

Phone: _____

SPOUSE EMPLOYER INFORMATION

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: _____

Rebound PT
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: Rebound PT 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. <p style="text-align: right;">Initials: _____</p>			
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. <p style="text-align: right;">Initials: _____</p>			
LIABILITY I know and agree that: Rebound PT is not responsible for loss or damage to personal valuables. <p style="text-align: right;">Initials: _____</p>			
WAIVER AND RELEASE I hereby release, discharge and acquit: Rebound PT 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 Medical Technician, physician or urgent care services. <p style="text-align: right;">Initials: _____</p>			
AUTHORIZATION OF PAYMENT I hereby assign all benefits directly to: Rebound PT 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. <p style="text-align: right;">Initials: _____</p>			
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: <ul style="list-style-type: none">- 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. <p style="text-align: right;">Initials: _____</p>			
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 _____	Date _____

Consent for Electronic Communication Text

The following consent form allows you to authorize our practice to communicate with you by text and/or email.

Email Communication

Email messages may not be transmitted in a secure manner with the risk that unauthorized third parties may access your personal health information.

May we send you email communications regarding your appointments, your health care services, and marketing materials? **Yes** **No**

By providing your email address below, you consent to email communications despite the potential risk of unauthorized access to your health information.

Email Address: _____

Text Messaging

Text messages are not transmitted in a secure manner and there is a risk that unauthorized third parties may gain access to the text messages.

May we send you text messages regarding your appointments, your health care services, and marketing materials? **Yes** **No**

By providing your text number below, you consent to text messaging despite the potential risk of unauthorized access to your health information.

Number to Text: () ____ - _____

Right to Revoke

You may revoke this Consent at any time in writing. Your revocation will be acted upon and implemented upon receipt of your written revocation except to the extent the Clinic has relied upon this Consent.

Signature

Name

Date

Name _____ Today's Date _____

Preferred Name _____ Preferred Pronoun she/her he/him they/them

Date of Birth _____ Social Security Number - - Height _____ Weight _____

Occupation _____ Working: Full time ___ Part time ___ Not working ___

Do you have a pacemaker? Yes No Are you pregnant? Yes No

Exercise: _____

How many times per week do you complete at least 20 minutes of exercise? _____

Other physical/recreational activities: _____

Alcohol Consumption (# of Drinks) per week _____ Cigarettes / Cigars per week _____

In the past 6 months, have you had:

Difficulty with bowel/bladder control	Yes	No		Numbness	Yes	No
Numbness in the genital or anal area	Yes	No		Vision/hearing problems	Yes	No
			Weakness	Dizziness or fainting	Yes	No
			Unexplained weight change	Chest pain	Yes	No

Other _____

Have you ever been diagnosed as having any of the following?

Cancer	Yes	No	If yes, what kind? _____					
Heart Problems	Yes	No	Rheumatoid Arthritis	Yes	No	Chemical dependency/alcoholism	Yes	No
High Blood	Yes	No	Osteoarthritis	Yes	No	Anxiety or panic disorders	Yes	No
Pressure Stroke	Yes	No	Hepatitis/HIV/AIDS	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Neurologic disease	Yes	No	If yes, specify _____		

Other _____

How many times have you fallen in the past 12 months? _____

Do you feel unsteady when standing or walking? Yes No Do you worry about falling? Yes No

Please list at least 3 activities that you are unable to do or have difficulty with as a result of your problem. For each activity you list, rate your current ability to perform that activity on the 0-10 scale below.

0=unable to perform activity 10=able to perform activity at the same level as before

Activity 1: _____ Score 0-10: _____

Activity 2: _____ Score 0-10: _____

Activity 3: _____ Score 0-10: _____

Any surgeries or conditions for which you have been hospitalized that may pertain to your current condition?

DATE	SURGERY / HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications prescriptions, herbal remedies and over the counter in any form are you currently using?

Patient/Guardian Signature

Relationship

Today's Date

ACUPUNCTURE HEALTH HISTORY

Date of Evaluation ___/___/___

Name (first/middle initial/last) _____ Age ___ D.O.B. ___/___/___

Referring Physician _____

Please list below in order of importance to you the health concerns you are looking for help with.

1. _____

When did this problem begin? _____ How did it begin? _____

Since your problem began is it ___Improving ___Staying the same ___Worsening

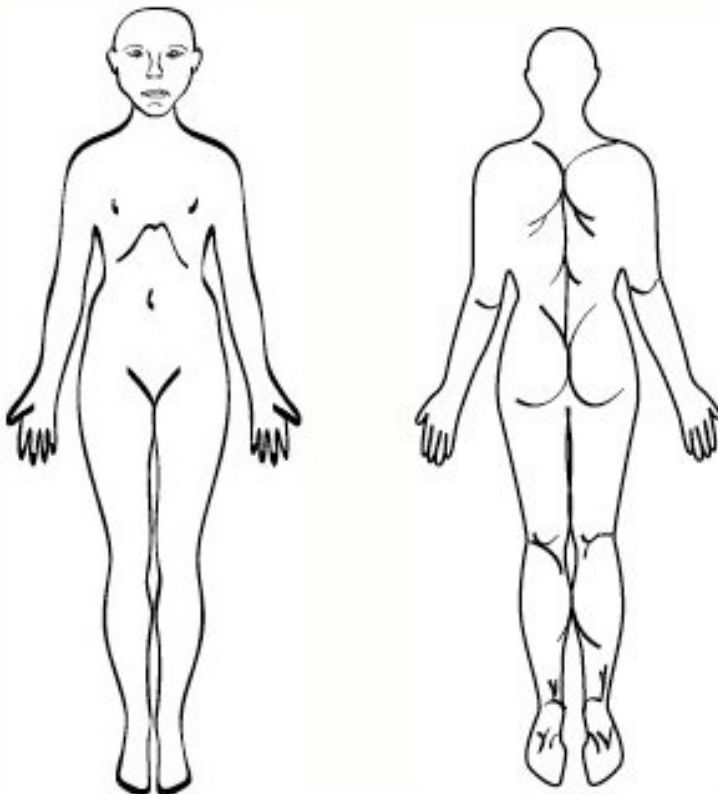
2. _____

When did this problem begin? _____ How did it begin? _____

Since your problem began, is it ___Improving ___Staying the same ___ Worsening

3. Please note on the diagram where you're experiencing pain (using the appropriate letters)

T = Tingling, / D = Dull, / S = Sharp, / N = Numbness, / B = Burning, / R = Radiating, / A = Ache



4. Is your pain?

Constant Intermittent

5. Express your pain on a scale of 0-10 (10 being extreme):

_____ At present _____ At best _____ At worst

6. Are there any activities or positions that significantly worsen your symptoms?

Sitting Standing Walking Lifting Lying down Ice Heat Coughing/Sneezing
 Bending Bowel or bladder movements Other _____

7. Are there any activities or positions that significantly improve your symptoms?

Sitting Standing Walking Lifting Lying down Ice Heat Pain medications
 Bending Other _____

8. What part of the day do you feel best? _____ Worst? _____

9. Do you wake up at night due to pain? Yes No

10. Are you currently receiving the following treatment with another provider?

Physical Therapy Chiropractic Massage Home Healthcare Services Skilled Nursing Facility Services
 Other: _____

11. Have you had prior treatment(s) for this condition?

Physical Therapy Chiropractic Injections Massage Surgery Acupuncture
 Other: _____

12. Recent diagnostic tests? X-ray CT Scan MRI EMG Bone Scan

Other: _____

13. Please list all medications you are currently taking.

14. Have you ever had any of the following? If so, please circle when it occurred **C**=Currently or **P**=Past

C P Anxiety disorder	C P Emphysema	C P Rheumatoid
C P Arthritis	C P Fatigue	C P Ringing in ears
C P Asthma	C P Fever	C P Seizures
C P Bladder problems	C P Head injury	C P Shingles
C P Blood clots	C P Headaches/ Migraines	C P Skin problems
C P Bowel problems	C P Heart problems/Heart attack	C P Sleeping problems
C P Breathing problems	C P Hernia	C P Smoking
C P Broken bones	C P High blood pressure	C P Strokes
C P Cancer	C P HIV/AIDS	C P Sweating
C P Chills	C P Kidney problems	C P Ulcers
C P Circulatory problems	C P Liver/Gallbladder	C P Vomiting
C P Depression	C P Major trauma	C P Weakness
C P Diabetes	C P Metal implants	C P Weight loss/ Weight gain
C P Dizziness	C P Nausea	C P women) menstrual problems/ ovarian problem
C P Easy bleeding	C P Osteoporosis	C P women) hormonal changes
C P Easy bruising	C P Pacemaker	menopaus
C P Elective surgery	C P Pregnancy	



INFORMED CONSENT TO RECEIVE ACUPUNCTURE TREATMENT

By signing below, I do hereby voluntarily consent to be treated with acupuncture and Oriental medicine by a licensed acupuncturist. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioner.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin and/or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment and very rarely lung puncture (pneumothorax). I understand that I may refuse this therapy at any time.

Direct Moxibustion/Infrared Mineral Lamp: I understand that I may receive direct moxibustion/infrared mineral lamp as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: a risk of burning or scarring, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Electro-Acupuncture: I understand that I may receive electro-acupuncture as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Cupping: I understand that I may receive cupping as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: deep redness, discoloration or bruising, on rare occasions blistering may occur, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Acupressure/Tui-Na Massage: I understand that I may receive acupressure/tui-na massage as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy at any time.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder, blood clots, or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I understand that there are no guarantees concerning treatment. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that I am free to refuse or stop treatment at any time.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PARENT/GUARDIAN must sign if patient is under 18 years of age

Signature: _____ Date: _____

L.Ac: _____ Date: _____



PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Rebound Physical Therapy. We bill your insurance as a courtesy to you, but you are ultimately responsible for paying for your care. Your insurance may require authorization for subsequent visits, and if you choose to be seen without authorization you may be responsible for the full cost of the visit. Call the number on the back of your insurance card to find out what your physical therapy, occupational therapy or acupuncture benefits and what your authorization requirements are.

If you do not have insurance, we offer a discount if you pay at the time of service. That discount is not available retroactively or if we bill any insurance. If you have questions contact one of our Patient Account Specialists at (541) 585-2541.

Please read carefully and initial each space below to show your understanding and agreement to these key points:

_____ I authorize direct payment from my insurance carrier to Rebound Physical Therapy. I will update Rebound
Initials immediately if there is any change to my insurance or to my contact information. I understand that if a change in insurance is not reported to Rebound immediately, there may be a lapse in coverage that can cause me to be responsible for the full cost of visits during that lapse.

_____ Rebound will attempt to verify my current insurance benefits, but verification of eligibility, benefits, or
Initials authorization is not a guarantee of payment. Furthermore, I understand that the information we receive from your insurance carrier may be incomplete or inaccurate. I understand that I am responsible for knowing my specific insurance plan coverage. I understand that I am responsible for paying for the care I receive regardless of what my insurance plan does or does not pay.

_____ I understand that depending on my specific insurance plan that I may owe a co-pay, deductible, or percentage of
Initials charges. If care is authorized by my insurance, I may still owe these expected payments depending on my insurance coverage. Co-payments are due at each visit. Rebound will refund any overpayment when my therapy is finished. I understand that I am responsible for all charges that are not paid by my insurance.

_____ I will contact the clinic at least 24 hours in advance if I am not able to keep any scheduled appointment.
Initials I acknowledge that failure to do so may result in a \$40.00 fee that will be my responsibility.

I have read this agreement and understand that regardless of my insurance benefits or lack thereof, I am responsible for payment of my account. I agree to pay for costs associated with third party collections and reasonable attorney fees if I fail to pay my bill within six months of my last visit.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

PARENT/GUARDIAN must sign if patient is under 18 years of age
SIGNATURE: _____

DATE: _____

*** Please ask the receptionist if you wish to have a copy of this form.**

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.

• **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 With 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 your 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.**

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.