

Our Multispecialty Team Welcomes You!



arizonapain**treatmentcenters**



MODERN AMBULATORY SURGERY CENTER



McDowell
ambulatory surgery center

Minimally Invasive
SPINE

Arizona's Minimally Invasive & Endoscopic Spine Surgery Specialists



You may see these names listed on your Explanation of Benefits from your health insurance carrier.
Questions? Contact your assigned account representative.

Who may we thank for referring you to our office? ☐ Medical physician _____
☐ Chiropractor _____ ☐ Family or friend _____ ☐ Internet ☐ Insurance company

PATIENT INFORMATION (Please complete all fields. If it does not apply or you do not want to provide, please write NA)

Last name _____ First name _____ Middle initial _____ Birthdate _____ Age _____
Street address _____ Apt # _____
City _____ State _____ Zip code _____
Home (_____) _____ Cell (_____) _____ Alt/work (_____) _____ Email _____
Driver's license _____ SS # _____ Male/Female _____
Marital status: ☐ Single ☐ Divorced ☐ Widowed ☐ Partner ☐ Married. Name of spouse _____
Race _____ Ethnicity _____ Primary Language _____
Employer _____ Occupation _____
Emergency contact _____ Relationship _____ Phone (_____) _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____
Address _____ City / State / Zip _____ Phone (_____) _____

ARE YOUR SYMPTOMS RELATED TO AN ACCIDENT? ☐ Yes ☐ No ☐ Don't know. Date of accident _____
If yes, what type? ☐ Auto ☐ On the job ☐ Other _____ Date reported _____
Is there an open claim related to this injury? ☐ No ☐ Yes State in which accident occurred _____

APPOINTMENTS

We ask that our patients come to their appointments 30 minutes before their scheduled time in order to fill out needed paperwork. If you are late, we will need to reschedule your appointment for a later time and date at our discretion.

PERMISSION FOR TREATMENT

I authorize the staff at "the Practice" to examine me and render treatment they deem necessary.

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize "the Practice" and its member physician to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate treatment and payment by third parties, collection of data for purpose of utilization review, quality assurance, or medical outcome evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, Managed Care organizations, IPAs or third party payers or any organizations contracting with any of the entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary or specialist physician that is directly or indirectly responsible for my medical care or the payment thereof.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed and agree to the Notice of Privacy Practices of "the Practice," which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information.

Print Name _____ Signature _____ Date _____

Date: _____

DOB: _____

Last name: _____ First name: _____

List other physicians you have seen regarding your condition *(specifically include any Rheumatologists, Neurologists, Orthopedic*

Surgeons, Spine Surgeons, or Chiropractic Physicians): _____

| Main pain complaint(s) | Date started | Pain scale (0-10) |
|------------------------|--------------|-------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |

| Check whether you have had these treatments | Approx last treatment | Approx relief % |
|---|-----------------------|-----------------|
| Chiropractic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| Physical therapy <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| Massage therapy <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| Psychology for pain <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |

| Check whether you have had these injections | Approx Date | Relief |
|---|-------------|--|
| Epidural Steroid Injection <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Facet Joint Injection or facet block <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| SI Joint Injection <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiofrequency Ablation <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Trigger Point Injection <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

* List any other injections (joint, tendon, bursa, etc.): _____

PLEASE INDICATE IF YOU HAD, OR CURRENTLY HAVE, THE FOLLOWING MEDICAL PROBLEMS:

| | | |
|---|---|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker/defibrillator |
| <input type="checkbox"/> Bleeding or blood disorder | <input type="checkbox"/> Lungs/Shortness of Breath | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Kidney/Genitourinary | <input type="checkbox"/> Bladder/Bowel incontinence | <input type="checkbox"/> Stomach/Intestine/Acid reflux |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid or another hormone |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headache | <input type="checkbox"/> Stroke/TIA/paralysis |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Fracture | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Joint/Muscle/Rheumatoid/Gout | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Depression/Anxiety/other |
| <input type="checkbox"/> Suicidal ideation/attempt | <input type="checkbox"/> Fever recent/current | <input type="checkbox"/> Other |

If **yes** to any of the above please explain and provide approximate date: _____

Family History

Mother: Alive or Deceased _____ Her medical conditions _____

Father: Alive or Deceased _____ His medical conditions _____

Do you smoke?

Do you drink alcohol?

List any diagnostic tests you have had for this condition (MRIs, X-Rays, CT Scans, EMGs, etc.)

| Date | Test | Body Part | Facility |
|------|------|-----------|----------|
|------|------|-----------|----------|

List all surgeries for brain, spine, joint, muscle and nerve (or any other major surgeries)

Do you have **allergies** to latex, adhesive tape, contrast dye, iodine/shellfish or **medications**?

Please list the allergy and the reaction. _____

Have you had any problems with surgery or anesthesia?

Date/Reaction:

Is there anything else in your past medical history that you feel is important to your care here?

Pharmacy Name: _____ Phone # _____ Street: _____

Current medications

| Name | Strength | Take | Route | Frequency |
|------|----------|------|-------|-----------|
|------|----------|------|-------|-----------|

Mark each box that applies

Male [] Female []
Are you under the age of 45? Yes [] No []

Is there any family history of substance abuse?

| | |
|--------------------|--------------------------|
| Alcohol | Yes [] No [] |
| Illegal Drugs | Yes [] No [] |
| Prescription Drugs | Yes [] No [] |

Do you have personal history of substance abuse?

| | |
|--------------------|--------------------------|
| Alcohol | Yes [] No [] |
| Illegal Drugs | Yes [] No [] |
| Prescription Drugs | Yes [] No [] |

Do you have a history of being sexually abused? **Yes [] No []**

Do you have any of the following psychological diagnoses?

| | |
|-----------------------------------|--------------------------|
| ADD, OCD, bipolar, schizophrenia? | Yes [] No [] |
| Depression? | Yes [] No [] |

Signature_____

Date_____

I understand I may be a patient of:

Arizona Pain Treatment Centers, PC
McDowell Ambulatory Surgery Center, LLC
Modern Ambulatory Surgery Center, PC
On-Call Anesthesia Surgical, LLC
Minimally Invasive Spine, LLC

Hereafter referred to as “The Practice.”

I understand that Azmi Nasser, D.O. has a financial interest in McDowell Ambulatory Surgery Center, LLC.

Patient printed name

Patient signature

Date

Advance Directives

We are required to comply with federal and state law regarding advance directives for adults and include this information in your medical chart. *If you have a Living Will or Medical Power of Attorney, please bring it to your next appointment so we may scan it into your chart.*

An “Advance Directive” is a general term that refers to your oral and/or written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and a medical power of attorney. If you would like a copy of the Official AZ State advance directive forms, please visit http://www.azsos.gov/adv_dir/

☐ **I have a Medical Power of Attorney.**

☐ **I have a Living Will.** My Living Will

(Please select one) **Does** **Does Not** contain a DNR (Do Not Resuscitate) order. ***

☐ **I have neither of the above.**

***** “Do Not Resuscitate” directives are not accepted by “the Practice” and you will asked to sign an override if your Living Will contains one.**

1301 E. McDowell Rd., Suite 100, Phoenix, AZ 85006 | Phone: 602-265-8800
4860 E. Baseline Rd., Suite 103, Mesa, AZ 85206 | Fax: 602-265-8151

**Assignment of Benefits and Designation of “The Practice” as
Authorized Representative**

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Signature

Date

Patient Billing Information

Date _____

Patient's Name: _____

Please complete each box. If it does not apply, please write NA.

HEALTH INSURANCE PRIMARY:

Insurance Co _____ Telephone # to verify benefits: _____

Name of Insured: _____

Insured's Soc. Sec. # _____ DOB _____

Group # _____ Policy # _____

Mail claims to: _____

HEALTH INSURANCE SECONDARY:

Insurance Co _____ Telephone # to verify benefits: _____

Name of Insured: _____

Insured's Soc. Sec. # _____ DOB _____

Group # _____ Policy # _____

Mail claims to: _____

Workers' Compensation Insurance Company:

Insurance Co _____ Address: _____

Phone: _____ Case Manager: _____ Date of Injury _____

Claim #: _____ Is Claim still Open? _____

PERSONAL INJURY

Date of Injury: _____

Auto Insurance Coverage: (Your auto insurance)

Insurance Co: _____ Name of Insured: _____

Address: _____

Insurance Phone: _____ UM/UIM Coverage: _____

Auto Insurance Coverage: (Medpay Claim)

Insurance Co: _____ Name of Insured: _____

Address: _____

Insurance Phone: _____ Adjuster: _____

Medpay Limits: \$ _____ Is Claim Open? _____ Claim #: _____

Third Party/Liability Insurance Company: (Insurance info for at-fault vehicle)

Insurance Co _____ Name of Insured: _____

Address: _____ Adjuster Phone: _____ Adjuster: _____

Is claim still open? _____ Policy/Claim #: _____

Attorney's name:

Attorney's Name: _____ Law Firm: _____

Phone: _____ Contact Person _____ E-Mail _____

Address: _____ Liens to file: _____ County _____ Attorney _____

HIPPA RELEASE FORM

Patient Name: _____ DOB: _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

| | | |
|----------------------|--------------------------|-------------------------|
| _____ <i>Name</i> | _____ <i>Relation</i> | _____ <i>Phone #</i> |
|----------------------|--------------------------|-------------------------|

| | | |
|----------------------|--------------------------|-------------------------|
| _____ <i>Name</i> | _____ <i>Relation</i> | _____ <i>Phone #</i> |
|----------------------|--------------------------|-------------------------|

| | | |
|----------------------|--------------------------|-------------------------|
| _____ <i>Name</i> | _____ <i>Relation</i> | _____ <i>Phone #</i> |
|----------------------|--------------------------|-------------------------|

| | | |
|----------------------|--------------------------|-------------------------|
| _____ <i>Name</i> | _____ <i>Relation</i> | _____ <i>Phone #</i> |
|----------------------|--------------------------|-------------------------|

This authorization will expire on: ____/____/____ (fill in date if less than 1 year) or one year after being signed.

Patient Signature

Date

Financial Policy and Disclosure of Fees

We can file insurance claims as a courtesy for our patients.

- **If your insurance changes, please notify us immediately so that we can be sure we have the appropriate referral and eligibility verification.**
- **You are responsible for all bills regardless of the type of insurance coverage you may have. Please contact your insurance company for any questions you have regarding coverage of services as it is your responsibility to know your benefits. We allow 60 days for your insurance to pay. After that time, the unpaid balance may be due and payable by the patient.**

Payment is expected at time of service. Patients are responsible for the appropriate co-payment, deductible, and co-insurance. Payment may be made with cash, credit card or money order. We do not accept personal checks at time of service. If your credit/debit or mailed check is returned for insufficient funds, you will be charged a \$35.00 service charge.

You are expected to pay all charges at the time of service if:

1. **You have no insurance coverage**
2. **Proper authorization/referral has not been received.**

Delinquent Accounts

Accounts past due are subject to collection. All fees including, but not limited to collection fees, attorney fees and court fees incurred shall become your responsibility in addition to the balance due this office.

Personal Injury

Our office will accept personal injury cases. If we accept your case on a lien basis, there will be a lien filing fee of \$30 applied to your account at the beginning of treatment for "the Practice." If you have a procedure done at either ambulatory surgery center, an additional \$30 fee will be added to your account to cover the ASC's costs for lien filing. Payment for treatment is not contingent on any settlement, judgment, or verdict which you may eventually recover. Lien cases will be reviewed periodically, and you may be required to make payments for continued care as determined by our office. You will be notified in advance.

Verification of Benefits

Our office will verify your insurance benefits as a courtesy, and it is not a guarantee of payment. Your insurance is a contract between you and your insurance company. You are liable for all expenses incurred and should any expenses remain unpaid for any reason, including but not limited to insurance deductible, policy limits or exclusions, you agree to pay any amounts remaining and owed to our office. We may offer to utilize both in and out-of-network patient benefits.

I have read and understand the financial policy. I acknowledge liability for all medical expenses incurred and agree to abide by the terms of this policy. Furthermore, with my signature, I authorize my physicians and their representatives to pursue collection via small claims court or higher court of law to assist me in collection of any outstanding bill.

Patient Signature _____ Date _____

Patient Name (print) _____

Patient Bill of Rights

- ✓ To be treated with respect, consideration and dignity
- ✓ To expect quality care and service from this facility
- ✓ To know, in advance, the estimated amount for services
- ✓ To full consideration of privacy concerning your medical care
- ✓ To information concerning your diagnosis, treatment and prognosis, to the degree known, in terms you can understand. If concern for your health makes it inadvisable to give such information to you, such information will be made available to an individual designated by you or to a legally authorized individual
- ✓ To receive from your physician sufficient information to be able to understand the procedure or treatment being received in order to sign the operative consent
- ✓ To confidential treatment of your medical records and to know that you are given the opportunity to approve or refuse their release to outside parties except when otherwise required by law
- ✓ To refuse treatment and to be informed of the consequences of this action
- ✓ To be given the opportunity to participate in decisions involving your healthcare, except when such participation is contraindicated
- ✓ To be informed of any persons other than routine personnel that would be observing or participating in the treatment
- ✓ To be informed of continuing healthcare you will receive following discharge
- ✓ To receive prompt pain assessment, treatment and information concerning pain prevention and relief measures
- ✓ To be free from all forms of abuse or harassment or from any act of discrimination or reprisal.
- ✓ If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.
- ✓ The patient's representative has the right to make informed decisions regarding the patient's care.
- ✓ If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

PATIENT CONCERNS AND/OR GRIEVANCES:

Persons who have a concern or grievance regarding "the Practice," including, but not limited to decisions regarding admission, treatment, discharge, denial of service, quality of services, courtesy of personnel or any other issue are encouraged to contact the Director of Operations or write a statement to:

Director of Operations: "The Practice" 1301 E. McDowell Road, Suite 100 Phoenix, AZ 85006

To file a complaint against an M.D., visit the Arizona Medical Board website to review options:

<https://www.azmd.gov/Complaint/ComplaintOL.aspx>

Medicare patients should visit the website to understand your rights and protections:

<http://www.cms.hhs.gov/center/ombudsman.aspx>

I have read and acknowledge my rights as a patient.

Signature _____ Date _____

The Practice

Privacy Notice

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

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

The ASC may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulation or state law. Disclosures of your protected health information for the purposes described in the Privacy Notice may be made in writing, orally or by facsimile.

Treatment: We will use and disclose your medical information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order blood work. We may also disclose protected information to physicians who may be treating you or consult with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

Payment: Your medical information will be used, as necessary, to obtain payment for services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your insurance company for utilization review. We may also disclose patient information to another provider in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia providers for payment of their services.

Operations: We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of the ASC and to provide quality care

to all patients. Health care operations activities include, but are not limited to, training programs including those in which student, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing, or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

Other uses of Disclosures: As part of treatment, payment and health care operations, we also use or disclose your protected health information for the following purposes:

- To remind you of your surgery date
- To inform you of potential treatment alternatives or options
- To inform you of health-related benefits or services that may be of interest to you.

We may release medical information about you to a friend, family member, or personal representative who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the surgery center. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through the research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility. We will always ask for your specific permission (authorization) if the researcher will have access to your name, address or other information that reveals who you are, or what will be involved in your care at the surgery center.

We will disclose medical information about you when required to do so by federal, state or local law.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be limited to someone able to help prevent the threat.

Uses and disclosures beyond treatment, payment and health care operations permitted without authorization of opportunity to object. Federal Privacy rules allow us to use or disclose your

protected health information without your permission for a number of reasons including the following:

- When legally required.
- When there are risks to public health.
- To report suspended abuse, neglect or domestic violence.
- To conduct health oversight activities.
- In connection with judicial and administrative proceedings.
- For law enforcement purposes.
- To Coroner, Medical Examiners, Funeral Directors and for organ donations.
- For research purposes.
- In the event of a serious threat to health or safety.
- For specified Government functions.
- For Worker's Compensation.

Uses and disclosures permitted without authorization but with opportunity to object. We may disclose your protected health information to your family member or a close personnel friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connecting with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described:

- Uses and disclosures with you authorize. Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.
- Your rights. You have the following rights regarding your health information:
 - The right to inspect and copy your protected health information. To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record.
 - The right to request a restriction on uses and disclosures of your protected health information. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.
 - The right to request to receive confidential communications from us by alternative means or at an alternative location. Requests must be made in writing to our Privacy Officer.
 - The right to request amendments to your protected health information. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.
 - The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the facility. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003.

Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during a 12-month period without charge. Subsequent accounting request may be subject to a reasonable cost-based fee.

- The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice, even if you have already received a copy of the notice or have agreed to accept this notice electronically.

Our Duties The facility is required by law to maintain the privacy of your health information and provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by the terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

Complaints You have the right to express complaints to the facility and to the Security of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility, you may submit a complaint to our Privacy Officer by sending it to:

The Practice

Attn: Director of Operations / Privacy Officer
Address: 1301 E. McDowell Rd., Suite 100
Phoenix, AZ 85006
Phone: 602-265-8800