***Patient Information:***

*Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: (circle) M F*

 *Last First M.I.*

*Birthdate: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_*

*Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Primary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Secondary)*

*E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Emergency Contact Information:***

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Employer Information:***

*Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Referred By:*** *(check all that apply)*

 *⬜ Friend/Relative: (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *⬜ Physician: (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *⬜ Website*

 *⬜ Advertisement or Other Website: (which?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *⬜ Other: (please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***\*Medical History: \*PLEASE COMPLETE ALL SECTIONS BELOW\****

*Date of Last Physical Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_*

***Past Medical History/Review of Systems: NONE INDICATED***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***NEUROLOGICAL*** | ***BLOOD*** | ***PULMONARY*** | ***CARDIOVASCULAR*** | ***SKIN/IMMUNE*** |
| * ***Migraine***
 | * ***Anemia***
 | * ***Asthma***
 | * ***Heart Disease***
 | * ***Arthritis/Joint Pain***
 |
| * ***Stroke***
 | * ***Bleeding Disorder***
 | * ***Tuberculosis***
 | * ***Chest Pain***
 | * ***Back/Neck***
 |
| * ***Seizures***
 | * ***Blood clots/DVT***
 | * ***Emphysema***
 | * ***High Blood Pressure***
 | * ***Skin Disorder***
 |
| * ***Depression***
 | * ***AIDS/HIV+***
 | * ***Pulmonary Embolism***
 | * ***Heart Attack***
 | * ***Autoimmune***
 |
| * ***Head Injury***
 | * ***Nose Bleeds***
 |  | * ***Heart Murmur***
 | * ***Lupus/Scleroderma***
 |
| * ***Other***
 | * ***Prior Transfusion***
 |  | * ***Swollen legs/ankles***
 | * ***Pigmentation***
 |
|  |  |  | * ***Palpitations***
 |  |
|  |  |  |  |  |
| ***GENERAL*** | ***HEAD/NECK*** | ***ENDOCRINE*** | ***GASTROINTESTINAL*** | ***ALLERGY*** |
| * ***Fever***
 | * ***Change in vision***
 | * ***Heat/Cold intolerance***
 | * ***Constipation***
 | * ***Tape Allergy***
 |
| * ***Weight loss/gain***
 | * ***Nasal blockage***
 | * ***Diabetes***
 | * ***Reflux disease***
 | * ***Environmental***
 |
| * ***Night Sweats***
 | * ***Sore throat***
 | * ***Thyroid problems***
 | * ***Diarrhea***
 | * ***Iodine Allergy***
 |
| * ***Loss of Appetite***
 | * ***Sinusitis***
 |  | * ***Hepatitis/Jaundice***
 | * ***Latex Allergy***
 |
|  | * ***Wear contacts/glasses***
 |  | * ***Frequent urinary infection***
 |  |
| * ***CANCER:***
 | * ***OTHER:***
 | ***COMMENTS:*** |

***Surgical History: Please list your surgical history and /or hospitalizations, serious accidents or injuries. Please include the date of the surgery, accident, or injury:* NONE INDICATED**

***Procedure Date***

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* Women’s Health History*** ⬜ N/A

Are You Pregnant? ⬜ Yes ⬜ No ⬜ Uncertain

Age of Menarche\_\_\_\_\_\_\_\_\_\_ Age of Menopause \_\_\_\_\_\_\_\_\_\_

Number of children \_\_\_\_\_\_\_\_\_\_\_\_\_ How were they delivered \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last mammogram (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous breast biopsies/surgeries, or other female organ surgery (date/reason/treatment): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* Difficulties with Local or General Anesthesia:*** ⬜ **None**

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* Allergies:***

Are You Allergic to Any Medications? ⬜ **None Known**

Please List: Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* Medications, Vitamins or Herbal Supplements You Take Now:***

Type Dosage Amount, if Known Take How Often

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\* Consumption of the Following:***

Tobacco ⬜ Never ⬜ Current: Amount Daily\_\_\_\_\_\_\_\_\_ Amount Weekly\_\_\_\_\_\_\_\_\_ ⬜ Previous \_\_\_\_\_\_\_

Alcohol ⬜ Never ⬜ Amount Daily \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Weekly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other ⬜ None ⬜ Amount Daily \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Weekly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aspirin ⬜ None ⬜ Amount Daily \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Weekly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Family History: Please check those that apply to your family members:* NONE INDICATED**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * ***Blood clots/DVT***
 | * ***Bleeding Disorder***
 | * ***Asthma***
 | * ***Breast Cancer***
 | * ***Stroke***
 |
| * ***High Blood Pressure***
 | * ***Heart Disease***
 | * ***Diabetes***
 | * ***Other:***
 |

**APPOINTMENT AND SURGERY CANCELLATION**

If you call at least 24 hours prior to the time of your appointment to cancel or reschedule there will be no charge, otherwise it is considered a “no-show” and you will be charged a fee of $100.00 in addition to any deposits already paid.

**NON-SUFFICIENT FUNDS**

If your check is returned for non-sufficient funds it will be necessary for us to pass on a $25.00 NSF fee from the bank.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Patient Name**

**AUTHORIZATION TO RELEASE**

**MEDICAL IMAGING RECORDS**

|  |
| --- |
|  |

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery.

This authorization is provided as a voluntary contribution in the interests of public education. I understand that such imaging records shall become the property of American Society of Plastic Surgery (ASPS) and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA. Neither I, nor any member of my family, will be identified by name in any publication, but I understand that in some circumstances, the images may portray features that will make my identity recognizable.

I authorize the release of my imaging records to be used without compensation for the purposes of advertising in our office photo album and in office seminars for prospective patients. These imaging records may also posted on our website or be used in print or television advertising.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Prichard or Dr. Repta. In addition, I understand that I have the right to inspect and copy the information that I have authorized to be disclosed.

I release and discharge Dr. Prichard, Dr. Repta and Dr. Andres, ASPS, and all parties acting under their license and authority from all rights that I may have in the imaging records and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the imaging records.

I understand that I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Advanced Aesthetic Associates, PLLC at 9250 North 3rd Street, Suite 1003 Phoenix, AZ 85020. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.

I certify that I have read the above Authorization and Release and fully understand its terms.

|  |  |
| --- | --- |
|  Signature |  Date |

I have read the above Authorization and Release. I am the parent, guardian, or conservator of , a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

|  |  |
| --- | --- |
|  Signature |  Date |
|  Witness Signature |  Date |

**CONSENT FOR USE OR DISCLOSURE OF INFORMATION**

Ihereby give consent to Advanced Aesthetic Associates, PLLC office to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations.

I hereby acknowledge that Advanced Aesthetic Associates, PLLC has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. The office provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices as outlined in the Notice of Privacy Practices.

I understand that I have the right to request, now and in the future, how protected health information is used or disclosed to carry out treatment, payment and health care operations. I understand that while the office is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

This consent shall be in force and effect as long as I am a patient at this practice. In addition, I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification, to my physician at this practice.

By signing this form I am hereby acknowledging that I have received the Notice of Privacy Practices. In addition, I am hereby giving consent for the office to use and/or disclosure my protected health information for the purposes of treatment, payment and health care operations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or personal representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient or personal representative

**NOTICE OF PRIVACY PRACTICES**

To our patients: This Notice describes how health information about you (as a patient of one of our practices) may be used and disclosed, and how you can get access to your health information. The federal regulation, known as the “HIPM Privacy Rule”, requires that we provide a detailed notice in writing of our privacy practices. We know that this Notice is long. However, the HIPAA Privacy Rule requires that we address many specific things in this Notice.

We reserve the right to make changes in this Notice and to make such changes effective for all Protected Health Information we may already have about you. If and when this Notice changes, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient. This information is called, “Protected Health Information” or “PHI”.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information

- Your privacy rights

- Our obligations concerning the collect use and disclosure of your health information

We may use and disclose your health information in the following ways:

The following categories describe the different ways in which we may use and disclose your health information.

1. Treatment. Physicians and staff may use or disclose your health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents (with your written consent and in compliance with state and federal laws.)

2. Payment. Our practice may use your health information to bill and payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose this information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your health information to bill you directly for services and items.

3. Health care operations. We may need to use and disclose your health information to be able to run our practice at the highest clinical standards and as effectively as possible. This could be used to evaluate the performance of our physicians and staff, to determine if our treatment plans are effective, or determine if there are other services we should be offering. We may also compare our clinical data with other practices; review it with medical students, medical faculty, technicians, and others for

 teaching and learning purposes. We will remove information that identifies you from this medical information.

4. Disclosures required by law. Our practice will use and disclose your health information when we are required to do so by federal, state, or local law.

 5. Appointment Reminders and Sign-In Sheets. We may want to call you by phone for appointment reminder purposes. Please advise us if you do not want us to call and leave appointment reminder messages at your home, possibly on your answering machine, or with any co-worker at your place of work. We may also use a “Sign-in” sheet at the front desk, for purposes of logging our patients as they arrive. We will make all efforts to keep this information from the view of others.

**Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4.When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6.To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you an inmate or under custody of a law enforcement official.

8. For Workers Compensation and similar programs.

**Your rights regarding your health information**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. Please note all requests for alternative communication must be made in writing to the appropriate name shown at the end of this Notice. You must specify how you would like to be contacted. We will accommodate reasonable requests.

1. You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request restrictions, you must your request in writing to the appropriate name shown at the end of this Notice. In your request, please include 1) The information you are requesting to be restricted 2) How you are requesting to restrict the information and 3) To whom you want those restrictions to apply.
2. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the appropriate name shown at the end of this Notice. If you request a copy of PHI about you, please note we may charge you a reasonable fee for completing your request.
3. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the appropriate name shown at the end of this Notice. You must provide us with a reason that supports your request for amendment. We are not required to make amendments if we feel the information is correct.
4. You have the right to request an “accounting” of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to six years other than disclosures made for: treatment, payment and health care operations; authorized disclosures under the Privacy Rule and disclosures made before April 14, 2003. If you wish to make such a request, please contact the appropriate name shown at the end of this Notice. The first accounting that you request in a 12-month period will be free; however we may charge you a reasonable fee for providing additional accountings in the same 12-month period.
5. Right to a copy of this Notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact the front desk staff.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practices or with the Secretary of the Department of Health and Human Services. To file a complaint with one of our practices, contact the appropriate name shown at the end of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this Notice or our health information privacy policies, please contact our Office Manager.