

All sections MUST be completed to insure proper reimbursement from your insurance company.

Patient Information:

Last Name		First Name		Middle Initial
Date of Birth	Sex	Marital Status	Social Security #	
Street Address		City		
State	Zip Code	Phone Number	Work Phone Number	
Email Address				
Employer			Employer Phone Number	
Emergency Contact		Relationship	Phone Number	

Race: American Indian or Alaskan Native Asian Native Hawaiian/Pacific Islander Black or African American White Hispanic Other
 Prefer not to answer

Are you of Hispanic or Latino Origin? Yes No Prefer not to answer

What is your preferred language at home? _____

Preferred Method of Contact:

Preferred Phone Number: _____

Preferred Time of Day: Morning Afternoon Evening

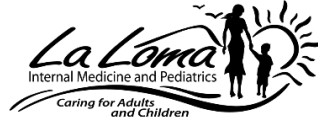
I would like to also receive texts for appointment reminders

Patient Portal

Please provide your email address to sign up for patient portal. Patient Portal allows patients 24-hour access to La Loma Internal Medicine and Pediatrics. You can access lab results, request prescriptions, send e-mails to the practice, fill out paperwork and much more!

Email Address: _____

Versatile Medicine PLLC, DBA



Responsible Party:

Last Name First Name Middle Initial

Date of Birth Sex Marital Status Social Security #

Street Address City

State Zip Code Phone Number Work Phone Number

Employer Employer Phone Number

Insurance Information Primary:

Insurance Name

Claims Street Address City

State Zip Code Policy ID Group Number

State Zip Code Phone Number Work Phone Number

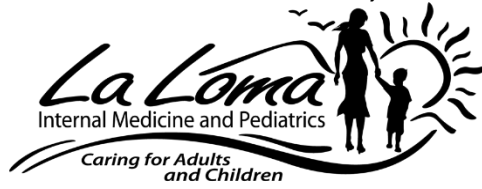
Cardholder Name Date of Birth Sex

Marital Status Social Security # Relationship to Patient Phone Number

Street Address City

State Zip Code Employer Employer Phone Number

Versatile Medicine PLLC, DBA



Insurance information Secondary:

Insurance Name

Claims Street Address

City

State

Zip Code

Policy ID

Group Number

State

Zip Code

Phone Number

Work Phone Number

Cardholder Name

Date of Birth

Sex

Marital Status

Social Security #

Relationship to Patient

Phone Number

Street Address

City

State

Zip Code

Employer

Employer Phone Number

Insurance Information Tertiary:

Insurance Name

Claims Street Address

City

State

Zip Code

Policy ID

Group Number

State

Zip Code

Phone Number

Work Phone Number

Cardholder Name

Date of Birth

Sex

Marital Status

Social Security #

Relationship to Patient

Phone Number

Street Address

City

State

Zip Code

Employer

Employer Phone Number

La Loma Notice of Privacy Practice Acknowledgement of Receipt

I acknowledge that I have received a copy of La Loma's Notice of Privacy Practices.

Signature of Patient/Patient's Agent or Representative

Printed Name of Patient/Patient's Agent or Representative

Relationship (if not signed by Patient)

Date Signed

Service Agreement:

The patient, or patients authorized agent or representative, agrees to the following terms of service:

CONSENT TO TREATMENT: The Patient voluntarily agrees to be evaluated/treated by Provider. This consent is valid and continuing until the Patient is discharged from care.

RELEASE OF INFORMATION: Provider may release all or any part of the patient's medical record to persons or entities engaged in the activities stated below:

- A. Insurance and Quality Review: Persons or corporations (including insurance companies, worker's compensation payers, hospital or medical service corporations, welfare funds, governmental agencies or the patient's employer.)
- B. Billing and Collections: Agents or employees of the Provider that process or duplicate medical records for billing and reimbursement purposes.
- C. Medical Audit: Persons or entities authorized by the Provider for purposes of conducting medical audit activities.
- D. Other Providers: Physicians and personnel involved in the patient's care to provide and manage the patient's health care. Also, information may be given to other health care providers to assure continuity of care.

I understand that I may revoke this authorization at any time, except to the extent the Provider has acted in reliance upon it or the disclosure is authorized by law. This consent to the release of patient information remains valid until expressly revoked by the Patient in writing.

FINANCIAL AGREEMENT: The Patient agrees in return for services provided, to pay his/her account balance in full or to make arrangements for payment which are satisfactory to the Provider. Any courtesy fees are only extended predicted upon full payment of fees at time of visit. If this account is not paid-in-full upon presentation of the statement, I agree to pay a monthly re-billing fee of \$5.00 per month until paid. To the extent not expressly prohibited by applicable law, the Patient agrees to pay all charges not paid in full by his/her insurance carrier or a third-party payer. In the event the account is turned over to an attorney or collection agency I agree to pay any and all actual collection charges and/or attorney's fees incurred in an amount not to exceed 50% of the balance due. Interest of 18% per year will be accrued on the principal balance. I further agree that the jurisdiction for any action filed for the purpose of collection any sums due on this account shall be the place where the contract was made, specifically Maricopa County, Arizona. A photocopy for facsimile of this assignment shall be considered as valid as the original.

ASSIGNMENT OF INSURANCE BENEFITS: If Patient is entitled to any policy of insurance which insures the Patient, or any party liable to the Patient then Patient hereby assigns all such benefits to be applied to the Provider. It is understood, however the Patient remains responsible for payment of his/her bill in full regardless of Patient's assignment of insurance coverage. I understand that I am responsible for my health insurance deductibles and co-payments.

PRICE QUOTES: The Patient understands that any price quotations given are estimates of expected services and not a guarantee.

MEDICARE PATIENTS: The undersigned certifies that all information given in applying for payment under title XVII of the Social Security Act is correct. Patient requests that payment of authorized benefits when received be made to the Provider. Patient authorizes release of any information needed to act on this request.

Videotaping and/or audio recording is strictly prohibited.

THE UNDERSIGNED CERTIFIES THAT (1) HAVE READ AND UNDERSTAND THESE CONDITIONS OF SERVICE, (2) I HAVE RECEIVED A COPY IF REQUESTED, AND (3) I AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT AS PATIENT'S AGENT TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

Signature: _____ Date: _____
(Patient or Patient's Agent or Representative)

Patient's Name: _____
(Please Print)

Relationship to Patient: _____



Release of Information:

In order to effectively communicate with you about your medical information, we ask that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information, account information, or respond to a message you left for your physician's office. In the event we cannot reach you,

- You may leave a message/voicemail with call back information ONLY.
- You may leave a message/voicemail with confidential/medical health information.

Phone Number: _____

I give permission for the following information to be shared with:

Name: _____ Phone: _____

Relationship: _____

Information to be shared: Billing Information Appointment Details Medical/Health Information

Name: _____ Phone: _____

Relationship: _____

Information to be shared: Billing Information Appointment Details Medical/Health Information

Name: _____ Phone: _____

Relationship: _____

Information to be shared: Billing Information Appointment Details Medical/Health Information

I understand I may revoke these permissions at any time and must do so in writing. This request supersedes any prior request for communication of information I have made.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (Print)

Relationship to Patient

Comprehensive Healthcare Database

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Current Complaints/Reason for Visit:

PAST MEDICAL PROBLEMS: (Please check any illnesses that you currently have or have had in the past)

- | | | |
|--|---|--|
| <input type="radio"/> Asthma | <input type="radio"/> Thyroid Problems | <input type="radio"/> Heart Problems |
| <input type="radio"/> Bleeding/Transfusions | <input type="radio"/> Cancer/Type: _____ | <input type="radio"/> Diabetes |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Lung Disease/Tuberculosis | <input type="radio"/> Emphysema |
| <input type="radio"/> Hepatitis | <input type="radio"/> Stroke | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Nervous Disorder | <input type="radio"/> Seizure/Epilepsy | <input type="radio"/> Ulcers |
| <input type="radio"/> Arthritis | <input type="radio"/> High Blood Pressure | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Other Please List: _____ | _____ | _____ |
| _____ | _____ | _____ |

PAST SURGERIES:

Date:	Type of Surgery/What was done:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST HOSPITALIZATIONS:

Date:	Where/ For What:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS: (Please list those that require a prescription as well as over the counter medications, vitamins, etc.)

Medication Name:	Dose/Frequency	Medication Name:	Dose/Frequency

ALLERGIES: (Please list allergies to specific medicines, foods, or substances, and reaction.)

Allergy:	Type of Reaction:	Allergy:	Type of Reaction:

PERSONAL HABITS: (Please circle yes or no to former or current use and indicate amount.)

Smoking YES/NO Packs per Day: _____
 Alcoholic Beverages YES/NO Number of Drinks per Day: _____
 Type of Drinks Consumed: _____
 Illicit Drugs YES/NO Type Used (Past and Current) _____
 Caffeine YES/NO Cups/Drinks per Day: _____

IMMUNIZATIONS: (Please circle immunizations you have received in the past 10 years)

Immunization:	Date Received:	Immunizations:	Date Received:
Tetanus		Influenza/Flu	
Pneumonia/Pneumovax		Hepatitis B	
TB Skin Test		MMR/Other	

FAMILY HISTORY: (Please check illnesses or conditions that have occurred in family members.)

- Cancer
- Heart Disease
- Kidney Disease
- Asthma
- High Blood Pressure
- Nervous Disorders
- Bowel Disturbances
- Multiple Allergies
- Stroke
- Diabetes
- Thyroid Conditions
- Tuberculosis
- Bleeding Problems
- Alcoholism
- High Cholesterol
- Other: _____

SOCIAL HISTORY:

Marital Status: _____

Occupation: _____

Number of Children: _____

Are you sexually active? YES/NO (Please circle)

Please list any other conditions or problems your physician should know about:

EMERGENCY CONTACT:

Name: _____ Telephone Number: _____

FORMER PHYSICIAN:

Name: _____

Specialty: _____

Address: _____

Telephone: _____

Pharmacy Information

Patient Name: _____

Patient DOB: _____

Please select the pharmacy you wish to receive prescriptions at from the list below. If your pharmacy is NOT listed, please select "OTHER" and write in the pharmacy's name and location.

Walgreens:

- 3361 N Litchfield RD (Litchfield and Indian School)
- 1451 N Dysart RD (Dysart and Thomas)
- 13014 W Camelback (Dysart and Camelback)
- 10710 W McDowell (107th Ave and McDowell)
- 10705 W Indian School (107th Ave and Indian School)
- 387 N Estrella PKWY (Estrella PKWY and VanBuren)
- 8301 W Camelback (83rd Ave and Camelback)
- 12244 W Cactus (El Mirage and Cactus)

CVS:

- 4890 N Litchfield RD (Litchfield and Camelback)

Fry's:

- 10675 W Indian School (107th Ave and Indian School)
- 1300 S Watson (Watson and Yuma)
- 1575 N Dysart (Dysart and McDowell)
- 390 N Litchfield (Litchfield and VanBuren)

Safeway:

- 14175 W Indian School RD (Litchfield and Indian School)
- 440 N Estrella PKWY (Estrella and VanBuren)

Costco:

- 10000 W McDowell (99th Ave and McDowell)

Sam's Club:

- 1459 N Dysart RD (Dysart and VanBuren)
- 8340 W McDowell (83rd and McDowell)

Walmart:

- 14200 W Indian School (Litchfield and Indian School)
- 13055 W Rancho Santé Fe BLVD (Dysart and McDowell)
- 1100 N Estrella PKWY (Estrella PKWY and I10)

MEDCO

EXPRESS SCRIPTS

OTHER (NAME OF PHARMACY AND LOCATION) _____

La Loma Internal Medicine and Pediatrics
Comprehensive Review of Systems

Instructions: Answer yes if the following problems are **FREQUENT** or **BOTHERSOME**. Explain all yes answers at the end of the last page.

GENERAL:

When was your last physical?	Date:	
Have you had recent UNEXPLAINED change of weight 10+ pounds?	Yes	No
Are you having any fevers?	Yes	No
Do you have excessive fatigue?	Yes	No
Do you have night sweats?	Yes	No
Do you have Hot Flashes?	Yes	No

EARS, EYES, NOSE, THROAT:

Do you have Nasal Congestion?	Yes	No
Do you have frequent runny nose?	Yes	No
Do you have a sore throat?	Yes	No
Have you noticed a change in your vision other than needing new glasses?	Yes	No
Are you having any hearing problems?	Yes	No
Do you have sinus issues?	Yes	No
When was your last eye exam?	Date:	

PULMONARY/LUNGS:

Are you unusually short of breath? If yes, AT REST or WITH ACTIVITY	Yes	No
Do you cough up sputum or mucus <u>most</u> days?	Yes	No
Do you cough up blood?	Yes	No
Have you had a cough for longer than two to three months?	Yes	No
Do you have pain with coughing?	Yes	No
Do you have pain with breathing?	Yes	No

CARDIOVASCULAR/HEART:

Do you get chest pains?	Yes	No
Do you get palpitations often?	Yes	No
Do your legs swell?	Yes	No
Do you have trouble breathing while lying flat?	Yes	No
Do you awaken at night gasping for air?	Yes	No
Do your legs cramp WHILE exercising or walking?	Yes	No
When did you last have your cholesterol checked?	Date:	
Was your cholesterol elevated?	Yes	No

Patient Name: _____

DOB: _____

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER, GALLBLADDER:

Do you have pain in your stomach or abdomen often?	Yes	No
Do you have frequent nausea?	Yes	No
Do you have frequent vomiting?	Yes	No
Do you have diarrhea?	Yes	No
Do you have bright red blood in your stools?	Yes	No
Do you have black tar-like stools?	Yes	No
Are you constipated?	Yes	No
Do you have difficulty swallowing?	Yes	No
Have you had a Colonoscopy or Flexible Sigmoidoscopy of your intestines?	Yes	No
*If you have, when? Date:	Were there any polyps?	Benign?

GENITOURINARY/GENITALS, KIDNEY, BLADDER, URINATION:

Do you have any burning or discomfort with urination?	Yes	No
Do you have any blood in the urine or is the urine dark (tea color)?	Yes	No
Do you urinate more frequently than normal?	Yes	No
Do you have difficulty starting a stream of urine or a weak stream?	Yes	No
Do you urinate more than once or twice per night?	Yes	No
Do you have problems with incontinence (Uncontrolled loss of urine)?	Yes	No
Do you have dribbling?	Yes	No
Do you have sores/lesions on your genitals?	Yes	No

HEMATOLOGIC (BLOOD):

Do you have problems with bleeding or a history of hemophilia? (Circle one)	Yes	No
Have you recently been told you are anemic?	Yes	No

ENDOCRINE (GLANDS) :

Do you have problems with excessive thirst?	Yes	No
Do you feel hotter or colder than those around you? (Circle which one or both)	Yes	No

MUSCULOSKELETAL:

Do you have any joint pain when exercising?	Yes	No
Do your joints swell or get red? (Circle which one or both)	Yes	No

NEUROPSYCHIATRIC (NERVES, BRAIN, MENTAL ILLNESS) :

Do you have problems with insomnia?	Yes	No
Have you ever suffered from depression?	Yes	No
Do you have frequent numbness of your extremities?	Yes	No
Do you have frequent weakness in your legs?	Yes	No

Patient Name: _____

OB/GYN AND BREAST (WOMEN ONLY):

When was your last menstrual period?	Date:		
Are they regular? (Days between Cycles?)		Yes	No
Number of pregnancies and/or deliveries			
Are you postmenopausal?		Yes	No
Are you having bothersome Hot Flashes?		Yes	No
Do you have problems with heavy vaginal bleeding or excessive menstrual pain?		Yes	No
Do you have vaginal discharge that is abnormal?		Yes	No
When was your last pap smear?	Date:		
Have you had a hysterectomy? If yes, was it complete or partial? (Circle one)		Yes	No
Have you had an abnormal Pap Smear?		Yes	No
If yes, When? Have your paps been normal since?		Yes	No
When was your last mammogram?	Date:		
Have you had an abnormal Mammogram? If yes, when?		Yes	No
Have your mammograms been normal since?		Yes	No
Have you had a Bone Density Scan? If yes, when?		Yes	No
Was it abnormal?		Yes	No
Do you take calcium?		Yes	No
Do you do regular self-breast examinations?		Yes	No
Do you use contraceptives? If yes, list the type of Contraceptive:		Yes	No

PROSTATE (MEN ONLY):

When was your last prostate exam?	Date:		
Do you have an enlarged prostate?		Yes	No
When was your last PSA (Prostate Specific Antigen blood test)?	Date:		
Do you have any testicular masses?		Yes	No
Do you have difficulty maintaining an erection?		Yes	No
Do you have penile discharge?		Yes	No

HEALTHCARE MTC:

Do you always wear a seatbelt?		Yes	No
Do you wear sunscreen if you out in the sun for any length of time?		Yes	No
Do you have a smoke detector in your home?		Yes	No
Do you have a living will or designated medical power of attorney?		Yes	No
Do you smoke? (If yes, how packs a day? _____)		Yes	No
Do you drink alcohol at all? (If yes, how many in how long? _____)		Yes	No
When was your last tetanus shot?	Date:		
Have you received the pneumonia vaccines? If so, When?			
When was the last flu shot you have received?			

REVIEWED AND DISCUSSED WITH PATIENT**PHYSICIAN SIGNATURE: _____ DATE: _____**

Patient Name: _____

La Loma Internal Medicine and Pediatrics

NOTICE OF PRIVACY PRACTICES

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.

We are committed to protecting the confidentiality of our medical information and are required by law to do so. This notice describes how we may use your medical information within La Loma Internal Medicine and Pediatrics and how we may disclose it to others outside of this practice. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have any questions.



How will we use and disclose your medical information?

Treatment: We may use your medical information to provide you with medical services and supplies. WE also may disclose your medical information to others who need that information to treat you, such as physicians, physician assistants, nurse practitioners, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment, providers and other involved in your care.

For example, we will allow your physician to have access to your La Loma medical record to assist in your treatment at another facility and for follow-up care

We may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

FAMILY MEMBERES AND OTHERS INVOLVED IN YOUR CARE: We may disclose your medical information to a family member or friend who is involved I your medical care, or to someone who helps to pay for your care. If you do not want La Loma to disclose your medical information to family members or others, please notify the front office staff at the time of your visit. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster.

PAYMENT: We may use and disclose your medical information to obtain payment for the medical services and supplies we provide to you. For example, your health plan or health insurance company may ask us to see parts of your medical records before they will pay us for your treatment.

FACILITY OPERATIONS: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the operations of the La Loma facility. We may use your medical information to conduct quality-improvement activities; to obtain audit, accounting or legal services; or to conduct business management and planning. For example, we may look at your medical record to evaluate whether La Loma personnel, your doctors, or other healthcare professionals did a good job.

RESEARCH: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

REQUIRED BY LAW: Federal, state, or local laws sometimes require us to disclose patient's medical information. For instance, we are required to report abuse or neglect and must provide certain information to law-enforcement officials in domestic-violence cases. We also are required to give information to the Arizona Worker's Compensation Program for work-related injuries.

PUBLIC HEALTH: We may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State of Arizona. We also may need to report patient problems with medications or medical products to the FDA or notify patients of recalls of products they are using.

PUBLIC SAFETY: We may disclose medical information for public-safety purposes in limited circumstances. We may disclose medical information to law-enforcement officials in response to a search warrant or a grand-jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct and to report criminal conduct at the La Loma facility. We also may disclose your medical information to law-enforcement officials and others to prevent a serious threat to health or safety.

HEALTH-OVERSIGHT ACTIVITIES: We may disclose medical information to a government agency that oversees a La Loma facility or its personnel, such as the Arizona Department of Health Services, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the facility's compliance with state and federal laws.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

ORGAN AND TISSUE DONTATION: We may disclose medical information to organizations that handle organ, eye, or tissue donation or transplantation.

MILITARY, VETERANS, NATIONAL SECURITY AND OTHER GOVERNMENT PURPOSE: If you are a member of the armed forces, we may release your medical information as required by military command authorities of the Department of Veterans Affairs. La Loma may also disclose medical information to federal officials for intelligence and national-security purposes or for presidential Protective Services

JUDICIAL PROCEEDINGS: La Loma facility may disclose medical information if the facility is ordered to do so by a court or if the facility received a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so you will have a chance to object to sharing your medical information.

INFORMATION WITH ADDITIONAL PROTECTION: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable diseases and HIV/AIDS, drug and alcohol-abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness, is treated differently than other types of medical information. For those types of information, La Lom is required to obtain your permission before disclosing that information to other in may circumstances.

OTHER USES AND DISCLOSURES: If La Loma wishes to use or disclose your medical information for a purpose that is not discussed in this notice, the facility will seek your permission. If you give your permission to our facility, you may take back that permission at any time, unless we already have relied on your permission

to use or disclose the information. If you ever would like to revoke your permission, please notify our Medical Records Department in writing.

WHAT ARE YOUR RIGHTS?

RIGHT TO REQUEST YOUR MEDICAL INFORMATION: You have the right to look at your own medical information and to secure a copy of that information. (The Law required us to keep the original record.)

This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, you must come into the office and fill out a medical release form. Due to high costs of duplicating medical records, there is a fee of \$25.00 for copying full medical records. Please allow 7-10 business days for the copying process to be completed.

RIGHT TO REQUEST AMENDMENT OF MEDICAL INFORMATION YOU BELIEVE IS ERRONEOUS OR INCOMPLETE: If you examine your medical information and believe some of the information is wrong or incomplete, you may ask us to amend your record. If you would like to request an amendment to your chart, please notify us in writing.

RIGHT TO REQUEST RESTRICTIONS ON HOW LA LOMA WILL USE OR DISCLOSE YOUR MEDICAL INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS: YOU HAVE THE RIGHT TO ASK US not TO MAKE USES OR DISCLOSURES OF YOUR MEDICAL INFORMATION TO TREAT YOU, TO SEEK PAYMENT FOR CARE, OR TO OPERATE THE La Loma facility. We are not required to agree to your request but, if we do agree, we will comply with that agreement. If you want to request a restriction, please send a request in writing to our Medical Records Department and describe your request in detail.

RIGHT TO A PAPER COPY: If you have received this notice electronically, you have the right to a paper copy at any time. Please notify the front office, and we will gladly give you one.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient medical information or how we will implement patient rights concerning their information. We reserve the right to change this notice and to make the provisions in our new notice effective for all medical information we maintain. If we change those practices, we will publish a revised Notice of Privacy Practices.

WHICH HEALTHCARE PROVIDERS ARE COVERED BY THIS NOTICE?

This Notice of Privacy Practices applies to La Loma and all personnel, volunteers, students and trainees. The notice also applies to Arizona Medical Partners, and other healthcare providers who come to the La Loma facility to care for patients. These providers include physicians, physician assistants, nurse practitioners, therapists and other healthcare providers not employed by La Loma, unless these other healthcare providers give you their own notice that describes how they will protect your medical information. La Loma may share your medical information with these other healthcare providers for their treatment purposes, to obtain payment for treatment, or to conduct healthcare operations. This arrangement is only for sharing information

and does not create any affiliation with these other providers. These other healthcare providers will have their own Notice of Privacy Practices that applies their own offices or facilities.

IF YOU HAVE ANY CONCERNS OR COMPLAINS

Please tell us about any problems or concerns you have with your privacy rights or how La Loma uses or discloses your medical information. If you have a concern, please contact us by writing or telephone.

If for some reason La Loma cannot resolve your concern, you may file a complaint with the Department of Health and Human Services Office of Civil Rights, we will not penalize you or retaliate against you in any way for filing a complaint with the Office of Civil Rights,

We are required by law to give you this notice and to follow the terms of the notice that is currently in effect. If you have any questions about this notice, or have further questions about how La Loma facilities may use and disclose your medical information please contact us in writing:

**La Loma Internal Medicine and Pediatrics
13055 W McDowell Rd Ste E 106
Avondale, AZ 85392**