



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 Alaska Native Asian Native Hawaiian or Pacific Islander Black or African American White Hispanic
 Other Prefer not to answer

Are you Hispanic or Latina 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

Please note: All patients who are web enabled will receive Appointment Reminders via patient portal as well.

Appointment reminders: Voice Message Text Message

Health Maintenance: Voice Message Text Message Email Letter

Prescription Confirmation: Voice Message Text Message

General Notifications: Voice Message Text Message Email Letter

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: _____



Responsible Party:

Last Name	First Name	Middle Initial
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Date of Birth	Sex	Marital Status	Social Security #
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Street Address	City
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State	Zip Code	Phone Number	Work Phone Number
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Employer	Employer Phone Number
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**Insurance Information:
Primary:**

Insurance Name

Claims Street Address	City
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State	Zip Code	Policy ID	Group Number
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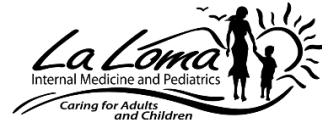
State	Zip Code	Phone Number	Work Phone Number
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Cardholder Name	Date of Birth	Sex
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Marital Status	Social Security #	Relationship to Patient	Phone Number
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Street Address	City
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State	Zip Code	Employer	Employer Phone Number
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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

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

Versatile Medicine PLLC, DBA

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

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) _____

Pediatric Health Database

Child's Name: _____ Age: _____ Date of Birth: _____

Parent/Guardian Name: _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____

Place of Birth (city, hospital): _____

List any problems during pregnancy: _____

Drugs, Alcohol, or Tobacco used during pregnancy: _____

Was the child born at term, sooner, or later: _____

Type of Delivery: Natural C-Section

Delivery complications: _____

Any complications the baby had after birth: _____

Duration of stay in the hospital for baby: _____

Birth Weight: _____ LB/KG Birth Length: _____ in/cm Head Circumference: _____ in/cm

Children at Home: Please list names and ages

_____	_____
_____	_____
_____	_____

Patient Name: _____ DOB _____ Date _____

Past Medical History

To be filled out by Parent or Guardian

Medical Allergies:

List Medications taken on a regular or needed basis:

List Medical problems/ Conditions:

Prior Surgeries:

Prior Hospitalizations:

Family History: Check Items if conditions present in parents, grandparents, etc....

Cancer (List types): _____

Heart Disease: _____ **High Blood Pressure:** _____ **Stroke:** _____

Nervous/Mental Health Disorders: _____ **Diabetes:** _____ **Alcoholism:** _____ **Kidney Disease:** _____

Digestive/Intestinal: _____ **Thyroid Disorders:** _____ **Asthma:** _____ **Allergies:** _____

Tuberculosis: _____ **Other:** _____

Social History:

School/Occupation: _____ **Grade :** _____

Smokers in household:

Does the patient use alcohol, tobacco or other drugs?

Patient Name: _____ **DOB** _____ **Date** _____

**La Loma
11/12 Year Well Child**

Date: _____

Name: _____ DOB: _____ Age: _____

Medications:		
Is your child on any medications?	YES	NO
If Yes, Please List:		
Allergies:		
Does your child have any allergies to medications?	YES	NO
Sensory:		
Vision:		
Does your child appear to be able to see well?	YES	NO
Hearing:		
Does your child appear to be able to hear?	YES	NO
Is your child's speech understandable 100% of the time by strangers? People?	YES	NO
Development:		
Does your child do well in school?	YES	NO
What kind of grades does your child usually get?	YES	NO
Nutrition: Does your child overall eat well (eat a generally diverse diet)? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Is your child on any supplements? E.g. Fluoride, Vitamins, or Iron	YES	NO

Do you have any concerns regarding your child? NO YES (Explain Below)

Signed _____ Printed Name _____
Relationship to Patient? _____ Date _____

La Loma Internal Medicine and Pediatrics
Child COMPREHENSIVE REVIEW OF SYSTEMS

Instructions: Answer yes if the following problems are CURRENT, FREQUENT or BOTHERSOME for your child.
 Explain all yes answers at the end of the last page.

Patient Name: _____ **DOB:** _____

GENERAL: _____ **Date:** _____

When was your child's last physical?	Date	
Has your child had a recent UNEXPLAINED loss of weight?	YES	NO
Does your child have a fever?	YES	NO
Does your child have excessive fatigue?	YES	NO
Does your child have an acceptable appetite?	YES	NO

EARS, EYES, NOSE, THROAT:

Does your child have any drainage from eyes?	YES	NO
Does your child have any redness or irritation in eyes?	YES	NO
Does your child complain of itchy watery eyes?	YES	NO
Does your child have a sore throat?	YES	NO
Does your child have Nasal Congestion?	YES	NO
Does your child have frequent runny noses?	YES	NO
Does your child suffer from frequent bloody noses? If so, how many per week?	YES	NO
Does your child complain of sinus pressure?	YES	NO
When was your child's last eye exam?	Date	

PULMONARY/ LUNGS:

Is your child frequently short of breath? (If yes, AT REST or WITH ACTIVITY)	YES	NO
Does your child cough up sputum or mucus <u>most days</u> ?	YES	NO
Does your child cough up blood?	YES	NO
Has your child had a continuous cough for longer than two to three months?	YES	NO
Does your child cough with exercise?	YES	NO
Does your child Wheeze?	YES	NO

CARDIOVASCULAR/HEART:

Does your child get chest pain often?	YES	NO
Does your child complain of a racing heart?	YES	NO
Do your child's extremities swell?	YES	NO
Does your child have trouble breathing while lying flat?	YES	NO
Does your child turn blue around the mouth or have rapid breathing during exercises?	YES	NO
Does the patient's mother or father have elevated cholesterol or heart disease?	YES	NO
Has your child ever had their cholesterol checked?	YES	NO

Patient Name: _____ DOB: _____

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER GALLBLADDER:

Does your child complain OFTEN of stomach pains?	YES	NO
Does your child complain of frequent nausea?	YES	NO
Does your child have frequent vomiting?	YES	NO
Does your child have frequent diarrhea?	YES	NO
Does your child have bright red blood in stools?	YES	NO
Does your child have black tarry stools?	YES	NO
Does your child have frequent constipation?	YES	NO
Does your child have difficulty swallowing?	YES	NO

GENITOURINARY/ GENITALS, KIDNEY, BLADDER, URINATION:

Does your child often complain of burning or discomfort with urination?	YES	NO
Does your child have any blood in urine?	YES	NO
Does your child urinate more frequently than normal?	YES	NO
Does your child get up to urinate more than once per night?	YES	NO
Does your child have problems with incontinence? (uncontrolled loss of urine)?	YES	NO
Does your child have sores / lesions on genitals?	YES	NO

HEMATOLOGIC (BLOOD)

Does your child have problems with bleeding or a history of hemophilia? (Circle which one)	YES	NO
Does your child have a history of anemia?	YES	NO
Does your child have swollen glands that do not resolve?	YES	NO

ENDOCRINE (GLANDS)

Does your child have problems with excessive thirst?	YES	NO
Does your child have dry brittle hair and nails?	YES	NO

MUSCULOSKELETAL / SKIN

Does your child complain often of joint pain?	YES	NO
Does your child have joints that swell or get red? (Circle which one or both)	YES	NO
Does your child often have a rash?	YES	NO

NEUROPSYCHIATRIC (NERVES, BRAINS)

Does your child often have trouble sleeping?	YES	NO
Does your child appear depressed or often sad?	YES	NO
Does your child complain of frequent numbness of legs and feet?	YES	NO
Does your child complain of frequent weakness in extremities?	YES	NO

Vaccines for Children (VFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider.

VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name: _____
Last Name
First Name
MI

2. Child's Date of Birth: ____ / ____ / ____

3. Parent/Guardian/Individual of Record: _____
Last Name
First Name
MI

4. Primary Provider's Name: _____
Last Name
First Name
MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in CHIP

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*



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 or to 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 Loma is required to obtain your permission before disclosing that information to other in many 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 trainee. 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 again 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**