Versatile Medicine PLLC, DBA

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: _____

**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**

## 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.

**ASSIGNEMENT 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: _____

**Versatile Medicine PLLC, DBA**

La Loma Internal Medicine and Pediatrics
Caring for Adults and Children

**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)

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

PAST SURGERIES:

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

PAST HOSPITALZIATIONS:

| 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 ◯ High Blood Pressure ◯ Stroke ◯ Bleeding Problems

◯ Heart Disease ◯ Nervous Disorders ◯ Diabetes ◯ Alcoholism

◯ Kidney Disease ◯ Bowel Disturbances ◯ Thyroid Conditions ◯ High Cholesterol

◯ Asthma ◯ Multiple Allergies ◯ Tuberculosis ◯ 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: _____

 Patient Name: _____

# 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 Santa 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

## Male Adolescent 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.

**GENERAL:** **Patient Name: _____ Date: _____**

| | | |
|---|---|---|
| Has your child had a recent UNEXPLAINED loss of weight? | YES | NO |
| Does your child have a fever? | YES | NO |

**EARS, EYES, NOSE, THROAT:**

| | | |
|---|---|---|
| Do you have Nasal Congestion? | YES | NO |
| Do you have a 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 have any hearing problems? | YES | NO |

**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 most days? | 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 |

**CARDIOVASCULAR/HEART:**

| | | |
|---|---|---|
| Do you get palpitations often? | YES | NO |
| Do you have trouble breathing while lying flat? | YES | NO |
| Do you awaken at night gasping for air? | YES | NO |

**GASTROINTESTINAL/STOMACH, INTESTINES, LIVER GALLBLADDER:**

| | | |
|---|---|---|
| Do you have pain in your stomach or abdomen often? | YES | NO |
| Does your child have frequent nausea? | YES | NO |
| Does your child have frequent vomiting? | YES | NO |
| Does your child have frequent diarrhea? | YES | NO |
| Do you vomit to lose weight? | YES | NO |
| Are you constipated? | YES | NO |

**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 colored)? | YES | NO |
| Do you urinate more frequently than normal? | YES | NO |
| Do you have sores/lesions on your genitals? | YES | NO |

**HEMATOLOGIC (BLOOD)**

| | | |
|---|---|---|
| Does you have problems with bleeding or a history of hemophilia? (Circle which one) | YES | NO |
| Do you have a history of anemia? | YES | NO |

**ENDOCRINE (GLANDS)**

| | | |
|---|---|---|
| Do you have problems with excessive thirst? | YES | NO |
| Do you have dry brittle hair and nails? | YES | NO |

**MUSCULOSKELETAL / SKIN**

| | | |
|---|---|---|
| Do you have any join pain when exercising? | YES | NO |
| Do your joints swell or get red? [] Swelling [] Gets Red | YES | NO |

**NEUROPSYCHIATRIC (NERVES, BRAINS)**

| | | |
|---|---|---|
| Have you suffered from depression? | YES | NO |
| Have you thought about hurting yourself? | YES | NO |

**GU (GENITOURINARY)**

| | | |
|---|---|---|
| Do you have any testicular masses (In your scrotum)? | YES | NO |
| Do you have any lesions on your penis? | YES | NO |
| Do you have any penile discharge? | YES | NO |
| Have you ever had a sexually transmitted disease? | YES | NO |
| Are you sexually active? | YES | NO |

**HEALTHCARE MTC**

| | | |
|---|---|---|
| Do you always wear a seatbelt in a motor vehicle? | YES | NO |
| Do you wear sunscreen if you are out in the sun for any length of time? | YES | NO |
| Do you Smoke? If yes, how many packs a day? | YES | NO |
| Do you drink alcohol at all? If yes, how many in how long? | YES | NO |
| Do you take drugs? | YES | NO |
| Are there any violence issues in your life? | YES | NO |

**Do you have any concerns or questions? [] YES [] NO**

| |
|---|
| |
| |
| |

**PATIENT NAME: _____**

**DOB: _____**

**DATE:_____**

**Vaccines for Children**
**(VFC) ProgramPatient**
**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 orlonger 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 receivingvaccine. 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 forthe 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 aFQHC/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 VFCprogram. 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 PURPROSE:** If you are a member of the armed forces, we may release your medical information as required by military command authorities of 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 change 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 REUEST 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 DICLSOSURES OF YOUR MEDICAL INFORMATION TO TREAT YOU, TO SEEK PAYMENT FOR CARE, OR TO OPERATE THE l 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**