Patient Information

TODAY'S DATE: _____

Patient Information

NAME: _____ AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ SEX: _____ MARITAL STATUS: _____

CITY: _____ STATE ___ ZIP _____ email: _____

DID YOU SEE OUR WEBSITE ___ Yes ___ No SOCIAL SEC #: _____

ARE WE IN YOUR PLAN DIRECTORY? ___ Yes ___ No DRIVERS LICENSE # _____ State _____

PERMANENT ADDRESS: _____

EMPLOYER: _____ CITY/ST/ZIP: _____

ADDRESS: _____ HOME PHONE #: _____

CITY/ST/ZIP: _____ WORK PHONE #: _____

PHONE #: _____ MOBILE PHONE#: _____

Responsible Party Information

NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____ EMPLOYER: _____

CITY/ST/ZIP: _____ ADDRESS: _____

HOME PHONE: _____ CITY/ST/ZIP: _____

SOCIAL SECURITY #: _____ WORK PHONE: _____

Primary Insurance (Please give your insurance card(s) to the receptionist)

INSURANCE CO.: _____ POLICYHOLDER'S NAME: _____

ADDRESS: _____ POLICYHOLDER SSN: _____

CITY/ST/ZIP: _____ POLICYHOLDER D.O.B: _____

PHONE # _____ POLICY #: _____

Effective dates: _____ through _____ GROUP #: _____

PLAN NAME _____ COPAY $ _____ RELATION TO PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____

Additional / Secondary Insurance

INSURANCE CO.: _____ POLICYHOLDER'S NAME: _____

ADDRESS: _____ POLICYHOLDER SSN: _____

CITY/ST/ZIP: _____ POLICYHOLDER D.O.B: _____

PHONE # _____ POLICY #: _____

Effective dates: _____ through _____ GROUP #: _____

PLAN NAME _____ COPAY $ _____ RELATION TO PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____

Miscellaneous

In case of emergency, notify _____ Relation to patient _____

Home phone _____ Work phone _____

Signature

The undersigned verifies that the above information is true and correct.

Signature: _____ Date: _____

(If patient is a minor - signature of parent/guardian)

Patient Communication Authorization

Date: _____

Patient's Name:_____

Patient's Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

❒ It's okay to call my home phone number. Okay to leave a message? ❒yes ❒no

❒ It's okay to call my mobile phone number. Okay to leave a message? ❒yes ❒no

❒ It's okay to call my work phone number Okay to leave a message? ❒yes ❒no

❒ Call only this number. _____ Okay to leave a message? ❒yes ☑no

❒ Do not speak to family members

I give permission to the individual(s) listed below to receive protected health information:

_____

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature _____ Date _____

PATIENT QUESTIONNAIRE

Patient's Name _____ Birth Date _____ Sex _____ S. M. LTP. W. D.

Address _____ Tel. No. _____

Insurance Co. _____ ☐HMO Copay $ _____ ☐PPO Copay $ _____ Primary care Physician _____ Occupation _____

Mail Claim To _____ Policy No. _____

Instructions: Put ☑ In Those Boxes Applicable To You And In The "Yes" Or "No" Space. If Lines Are Provided Write In Your Answer.

Family History

	Father	Mother	Brother 1	Brother 2	Brother 3	Brother 4	Sister 1	Sister 2	Sister 3	Sister 4	Spouse/ Partner	Children 1	Children 2	Children 3	Children 4	Children 5	Children 6
Age (if Living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma, Hives, Hay Fever																	
Blood Disease																	
Age (At Death)																	
Cause Of Death																	

Personal History

Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes
☐Scarlet Fever			Jaundice			☐Broken Bones ☐Cracked Bones		
Diphtheria			Epilepsy			Recurrent Dislocations		
Smallpox			Migraine Headaches			☐Concussion ☐Head Injury		
Pneumonia			Tuberculosis			Ever Been Knocked Unconscious		
Pleurisy			Diabetes			☐Food ☐Chemical ☐Drug Poisoning		
☐Rheumatic Fever ☐Heart Disease			Cancer			Explain		
☐Arthritis ☐Rheumatism			Colonoscopy / Sigmoidoscopy			Latex Sensitivity		
☐Bone Disease ☐Joint Disease			☐High ☐Low Blood Pressure			Chronic Fatigue Syndrome		
☐Neuritis ☐Neuralgia			Nervous Breakdown			Any Other Disease		
☐Bursitis ☐Sciatica ☐Lumbago			☐Hay Fever ☐Asthma			Explain		
☐Polio ☐Meningitis			☐Hives ☐Eczema					
☐Gonorrhea ☐Syphilis ☐HIV			Frequent ☐Colds ☐Sore Throat			Weight: Now One Yr. Ago		
Anemia			Frequent ☐Infections ☐Boils			Maximum When		

Allergies

Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes
☐Penicillin ☐Sulfa Drugs			Any Other Drugs			Any Foods		
☐Aspirin ☐Codeine ☐Morphine			Explain			Explain		
☐Mycins ☐Other Antibiotics			Iodine Or Radiologic Dye					
☐Tetanus ☐Antitoxin ☐Serums			Adhesive Tape			☐Nail Polish ☐Other Cosmetics		

Surgery

Have You Had Removed . . .	No	Yes	Have You Had Removed . . .	No	Yes	Have You . . .	No	Yes
Tonsils			☐Ovary ☐Ovaries			Had Hernia Repaired		
Appendix			Hemorrhoids			Had Any Other Operations		
Gall Bladder			Ever Have A Transfusion			Been Hospitalized For Any Illness		
Uterus			☐Blood ☐Plasma			Explain		

X-Rays

Ever Have X-rays Of . . .	No	Yes	Date	Disease Present
Chest				
☐Stomach ☐Colon				
Gall Bladder				
Extremities				
Back				
Mammogram				
Sigmoidoscopy / Barium Enema				
Other				

Review Of Systems

Do You Now Have Or Have You Ever Had . . .	No	Yes	Do You Now Have Or Have You Ever Had . . .	No	Yes
☐ Eye Disease ☐ Eye Injury ☐ Impaired Sight			Kidney ☐ Disease ☐ Stones		
☐ Ear Disease ☐ Ear Injury ☐ Impaired Hearing			Bladder Disease		
Any Trouble With ☐ Nose ☐ Sinuses ☐ Mouth ☐ Throat			Blood In Urine		
Fainting Spells			☐ Protein ☐ Sugar ☐ Pus ☐ Other In Urine		
Convulsions			Difficulty In Urination		
Paralysis			Narrowed Urinary Stream		
Dizziness			Abnormal Thirst		
Headaches: ☐ Frequent ☐ Severe			Prostate Trouble		
Enlarged Glands			☐ Stomach Trouble ☐ Ulcer		
Thyroid: ☐ Overactive ☐ Underactive ☐ Enlarged			Indigestion		
Enlarged Goiter			☐ Gas ☐ Belching		
Skin Disease			Appendicitis		
Cough: ☐ Frequent ☐ Chronic			☐ Liver Disease ☐ Gall Bladder Disease		
☐ Chest Pain ☐ Angina Pectoris			☐ Colitis ☐ Other Bowel Disease		
Spitting Up Blood			☐ Hemorrhoids ☐ Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Shortness Of Breath ☐ Exertion ☐ At Night			☐ Constipation ☐ Diarrhea		
☐ Palpitation ☐ Fluttering Heart			☐ Parasites ☐ Worms		
Swelling Of ☐ Hands ☐ Feet ☐ Ankles			☐ Any Change In Appetite ☐ Eating Habits		
Varicose Veins			☐ Any Change In Bowel Action ☐ Stools		
Extreme ☐ Tiredness ☐ Weakness			Explain		

Immunization - EKG

Have You Had . . .	No	Yes	Have You Had . . .	No	Yes
Smallpox Vaccination (Within Last 7 Years)			Polio Shots (Within Last 2 Years)		
Tetanus Shot (Not Antitoxin)			An Electrocardiogram When		
Hepatitis Vaccination					

Social History

Do You . . .	No	Yes	Do You Use . . .	Never	Occ.	Freq.	Daily
Exercise Adequately			Laxatives				
How?			Vitamins				
Awaken Rested			Sedatives				
Sleep Well			Tranquilizers				
Average 8 Hours Sleep (Per Night)			Sleeping Pills				
Have Regular Bowel Movements			Aspirins				
Sex - Entirely Satisfactory			Cortisone				
Like Your Work (Hours Per Day) ☐ Indoors ☐ Outdoors			Alcoholic Beverages				
Watch Television (Hours Per Day)			Tobacco: Cigarettes (Pks Per Day)				
Read (Hours Per Day)			☐ Cigars ☐ Pipe ☐ Chewing Tobacco				
Have A Vacation (Weeks Per Year)			☐ Snuff				
Have You Ever Been Treated For Alcoholism			☐ Other Drugs				
Have You Ever Been Treated For Drug Abuse			Appetite Depressants				
Recreation: Do You Participate In Sports Or Have Hobbies Which Give You Relaxation At Least 3 Hours A Week?			Thyroid Medication: ☐ No ☐ Yes, In Past ☐ None Now ☐ Now On Gr. Daily Have You Ever Taken: ☐ Insulin ☐ Tablets For Diabetes ☐ Hormone Shots ☐ Tablets ☐ No				

Women Only

Menstrual History . . .	No	Yes		No	Yes
Age At Onset			Are You Regular: ☐ Heavy ☐ Medium ☐ Light		
Usual Duration Of Period Days			Do You Have ☐ Tension ☐ Depression Before Period		
Cycle (Start To Start) Days			Do You Have ☐ Cramps ☐ Pain With Period		
Date Of Last Period			Do You Have Hot Flashes		
Pregnancies . . .	No	Yes		No	Yes
Children Born Alive (How Many)			Still Born (How Many)		
Cesarean Sections (How Many)			Miscarriages (How Many)		
Prematures (How Many)			Any Complications		

Emotions

Are You Often . . .	No	Yes	Are You Often . . .	No	Yes
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		

Five Points Health Center

Clinic Policies

Patient name: _____

Five Points Wellness Center is a medical marijuana recommendation center. A visit to our center does not constitute a doctor-patient relationship for any other reason than to determine if a recommendation for medical marijuana is right for you.

Our doctors are alternative medicine specialist, practicing under their naturopathic or homeopathic and integrative medical licenses. The services we offer are not reimbursed by medical insurance, and we will not offer assistance with filing an insurance claim.

As a matter of policy, our doctors will not consult with you about your medical condition, other than to determine if you qualify for a recommendation for medical marijuana. All of the medical records you submit to us will be placed in your chart. Our doctors do not normally review any medical records older than twelve months. Our doctors will review your presented medical records for the past twelve months to determine if you qualify for a recommendation for medical marijuana. Your medical records will not typically be examined by us for any other diagnoses, disease, or conditions; and should be evaluated more thoroughly by your primary care physician. We reserve the right to consult with your physicians to inform them of your medical care.

I have been presented with a copy of the clinics ”Notice of Privacy Policies”, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I place no additional restrictions concerning my personal medical information. I acknowledge that all of the information supplied by me in person and on the patient information forms is true and correct to the best of my knowledge.

Signed: _____ Date:_____

(If patient is a minor - signature of parent/guardian)

Five Points Health Center

Medical Records Statement

Patient name: _____ DOB: _____

The Arizona Department of Health requires our physicians to review your medical records, 1) including medical records from other treating physicians you may have seen in the past twelve months, 2) note your response to conventional medications and medical therapies, and 3) review your profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program Database; before we can recommend medical marijuana or cannabis for your debilitating medical condition.

The most common qualifying condition is severe and chronic pain; persisting for greater than three months, and severe enough to rate at least a number 7, 8, 9, or 10 (on a 0-10 scale). For pain that is less than severe and chronic, please see your primary care physician for treatment, and not a medical marijuana certification specialist.

Please check one of the boxes below:

❑ I have not seen a physician within the past twelve months, so there are no medical records that exist from this time period. Any prescription(s) less than one year old that were submitted to the Arizona Prescription Monitoring Program Database are refills from an original doctor's prescription(s) written more than a year ago.

❑ I have seen a physician within the past twelve months for which I have presented all my medical records that exist from this time period.

❑ I have seen other physician(s) within the past twelve months. I do not have a complete set of medical records with me at this time. I will request to have them sent to your office before my next visit, or I will bring them into the office with me during my next visit.

Signed: _____ Date:_____

(If patient is a minor - signature of parent/guardian)

Marijuana

What Is It?

Marijuana is a mixture of the fried and shredded leaves, stems, seeds, and flowers of the hemp plant. The mixture can be green, brown, or gray. Hemp's scientific name is Cannabis sativa.

A bunch of leaves seems harmless, right? But think again. Marijuana has a chemical in it called tetrahydrocannabinol. Better known as THC. A lot of other chemicals are found in marijuana too-about 400 of them, some of which can cause lung cancer. But THC is the main active ingredient.[1]

What Are the Common Street Names?

There are more than 200 slang terms for marijuana including:

- Pot
- Herb
- Weed
- Boom
- Mary Jane
- Gangster
- Chronic
- Bud
- Sinsemilla, ganja,hashish and hash oil (stronger forms of marijuana).

How Is It Used?

Marijuana is used in many ways. Some users brew it as tea or mix it with food. Others smoke blunts-cigars hollowed out and filled with the drug. And sometimes marijuana is smoked through a water pipe called a bong. The most common method is smoking loose marijuana rolled into a cigarette called a joint or nail.[2]

Short-term Effects of Using Marijuana

- Memory Problems
- Impaired Coordination
- Distortions in senses of sight, hearing, touch, time and depth.

Long-term Effects of Using Marijuana

- Increasing tolerance-The need for increasing amounts to feel effects.
- Permanent damage to thinking and reasoning ability.
- Chronic bronchitis, frequent chest colds, and pneumonia.
- Increased risk of lung or oral cancer.
- Weakened immune system.
- Damage to the reproductive system and infertility in both sexes.
- Miscarriage or brain damage to fetuses.

Addiction

Here's the thing: Once dopamine starts flowing, a user feels the urge to smoke marijuana again, and then again, and then again. Repeated use could lead to addiction, and addiction is a brain disease.

Smoking Marijuana Can Make Driving Dangerous

The cerebellum is the section of our brain that does most of the work on balance and coordination. When THC finds its way into the cerebellum, it makes scoring a goal in soccer or hitting a homerun pretty tough.

THC also does a number on the basal ganglia, another part of the brain that's involved in movement control.

These THC effects can spell disaster on the highway. Research shows that drivers on marijuana have slow reaction times, impaired judgment, and problems responding to signals and sounds on the road. In one study of 150 reckless drivers, 33 tested positive for marijuana.[1,4]

Smoking Marijuana May Lead to Lung Cancer

The list of negative effects goes on and on. Smoking marijuana may increase the risk of heart attack. Smoking marijuana may cause lung cancer-causing substances as tobacco. Plus, marijuana smokers tend to inhale more deeply and hold their breath longer than cigarette smokers do. So more smoke enters the lungs. Puff for puff, smoking marijuana may increase the risk of cancer even more than smoking cigarettes does.[4]

What About Medical Marijuana?

THC, the main active ingredient in marijuana, produces effects that potentially can be useful for treating a variety of medical conditions. It is the main ingredient in a pill that is currently used to treat nausea in cancer. It is the main ingredient in a pill that is currently used to treat nausea in cancer chemotherapy patients and to stimulate appetite in patients with wasting due to AIDS. Scientists are continuing to investigate other potential medical uses for cannabinoids.

However, smoking marijuana is difficult to justify medically because the amount of THC in marijuana is not always consistent. It would be difficult-if not impossible –to come up with a safe and effective use of the drug because you could never be sure how much THC you were getting. Moreover, the negative effects of marijuana smoke on the lungs will offset the helpfulness of smoked marijuana for some patients.

Medical Marijuana Program
Qualifying Patient Application Information

Please note that application information and other instructions may change. Please refer back to the ADHS website for the most current information.

Please read this information before beginning the application process.

1. Print and review the Qualifying Patient Checklist. This checklist will assist you in compiling the required information and supporting documentation in order to complete the online application process.
2. Visit the ADHS Medical Marijuana Frequently Asked Questions (FAQs) webpage for more detailed information and specifics regarding qualifying patients. http://www.azdhs.gov/medicalmarijuana/faqs/
3. Print the *Medical Marijuana Physician Certification* form from the ADHS website http://www.azdhs.gov/medicalmarijuana/physicians/. This form must be downloaded, taken to your physician, and completed. If there are any areas that are not completed, ADHS will not accept the application. You **must** use this form for your application; no other forms will be accepted.
4. Print, sign, and date the *Medical Marijuana Patient Attestation*. This form must be downloaded from the ADHS website at http://www.azdhs.gov/medicalmarijuana/patients/adult.htm
5. Before you begin your online application, you will need specific images and other documents (including those listed in #3 and #4 above) that must be uploaded with your application. The required documents and formatting instructions are listed in the Qualifying Patient Checklist.
6. Once all information and documentation from the Qualifying Patient Checklist has been obtained and properly formatted, you may begin the online application. Ensure all information is completed. After completing the fields, you will be prompted to upload the required documentation.
7. You will need a MasterCard or Visa to pay your application fee. A credit card, debit card, or pre-paid cards are accepted. Please note that application fees are non-refundable.
8. Once you have successfully paid the application fee, press "Continue" to return to the ADHS online system to print out your completed application. You should retain your application so it is accessible to you. You will need the application number and submission date for the system to find your application in the future.
9. Once successfully submitted through the ADHS online system, ADHS will review your application. If approved, you will receive an automatically-generated email indicating your approval. If more information is needed or the application has deficiencies, you will be notified and provided with further instructions on how to correct and resubmit your application.
10. Upon approval, your registry identification card will be mailed to you at the address you provided in the application.

***Designating a Caregiver**

If you have designated a caregiver within the ADHS online system, your caregiver must also apply. Your patient application must be completed and approved before your designated caregiver can apply through the ADHS online system. Your caregiver will need your Patient Application ID #, your full name and date of birth in order to begin the application process. Please note that your caregiver must also submit fingerprints to ADHS through the U.S. Mail as part of his or her application. Please direct your caregiver to the appropriate section on the ADHS website for more information: http://www.azdhs.gov/medicalmarijuana/caregivers/.

Medical Marijuana Program
Qualifying Patient Checklist

Please note that this checklist information and other instructions may change. Please refer back to the ADHS website for the most current information.

Print out and review this checklist **prior to** submitting your Qualifying Patient Application in the ADHS online system. This checklist will assist you in compiling the required information and supporting documentation. Application requirements are also outlined in Arizona Administrative Code (A.A.C.) R9-17-202.

You will be asked to enter the following information and submit the following supporting documents:

1. Application Information:
□ The patient's □ First name; middle initial, if applicable; last name; and suffix, if applicable □ Date of birth □ Gender
□ The identifying number on the applicable card or document (see Section 2 below for list of identification requirements and options). The patient must also enter the ID type, issuing state, and issued date.
□ The patient's residential address and county.
□ The patient's phone number.
□ The patient's email address where confidential information can be sent (free email address website links are provided within the application).
□ The patient's mailing address. Patient can check box if same as residential address.
□ The name, address, and telephone number of the physician attesting for the patient. This information must be obtained from the *Medical Marijuana Physician Certification* form.
□ The physician's license number, physician license state, and license type. This must be obtained from the *Medical Marijuana Physician Certification* form.
□ The patient's Qualifying Health Conditions that apply. This information must be obtained from the *Medical Marijuana Physician Certification* form.
□ If the patient is designating a caregiver, the following **caregiver** information: □ First name; middle initial, if applicable; last name; and suffix, if applicable □ Date of birth □ Gender □ Address and county where caregiver resides
□ Whether the patient is requesting authorization to cultivate marijuana plants.
□ If the patient designated a caregiver, if the caregiver is requesting to cultivate marijuana plants.
□ Whether the patient would like notification of any clinical studies needing human subjects for research on the medical use of marijuana.
□ If the patient is eligible for the Supplemental Nutrition Assistance Program (SNAP), documentation required.
□ If the patient is homeless, an address where the patient can receive mail.
2. Documentation Needed for Uploading • **The current photograph must be an image file (JPG, PNG, or GIF file format). The other supporting documents can be PDF documents or image files (JPG, PNG, or GIF file format). The recommended file type is PDF.** • **The size of the each file should not exceed 2MB.**
□ A current photograph of the patient. Photograph must be taken no more than 60 calendar days before the submission of the application. Photograph must be capable of producing an image:

- 2 inches by 2 inches in size with minimum dimensions of 600x600 pixels and maximum dimensions of 1200x1200 pixels.
- In natural color
- That is a front view of the individual's full face, without a hat or headgear that obscures the hair or hairline, with a plain white or off-white background
- That has between 1 and 1 3/8 inches from the bottom of the chin to the top of the head

□ A copy of the patient's:
- □ Arizona driver's license issued on or after October 1, 1996; **OR**
- □ Arizona identification card issued on or after October 1, 1996; **OR**
- □ Arizona registry identification card; **OR**
- □ Photograph page in the patient's U.S. passport; **OR**
- □ An Arizona driver's license or identification card issued before October 1, 1996 **AND** one of the following:
  - □ Birth certificate verifying U.S. citizenship
  - □ U.S. Certificate of Naturalization
  - □ U.S. Certificate of Citizenship

□ Signed and dated *Medical Marijuana Patient Attestation*. This must be downloaded from the ADHS website at http://www.azdhs.gov/medicalmarijuana/patients/adult.htm.

□ Physician-completed *Medical Marijuana Physician Certification Form*. This must be downloaded from the ADHS website at http://www.azdhs.gov/medicalmarijuana/physicians/.

□ SNAP documentation (if applicable): a copy of an eligibility notice or an electronic benefits transfer card demonstrating current participation in the U.S. Department of Agriculture Food and Nutrition Services, Supplemental Nutrition Assistance Program.

□ A valid and current Visa or MasterCard for payment. A credit card, debit card, or pre-paid cards are accepted.

Print Form

ARIZONA DEPARTMENT OF HEALTH SERVICES
MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA PATIENT ATTESTATION

I, _____, attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality of care.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, billing services, and a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition for directory purposes. This information may be provided to people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

NOTICE OF PRIVACY POLICIES

Revision Number 1.0.
January 2009

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At our clinic, we are committed to treating and using your protected health information responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you are seen at our clinic, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of our clinic, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
  - Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
  - Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
We are required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions, please contact the practice's Privacy Officer/Office Manager for additional information.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.