BAY ARTHRITIS
INSTITUTE

## PATIENT INFORMATION

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (  ) _____ CELL/WORK #: (  ) _____

SSN: _____ EMAIL: _____

SEX: M / F DOB: _____ AGE: _____

EMPLOYER'S NAME: _____ OCCUPATION: _____

MARITAL STATUS: _____ SPOUSE: _____

## INSURANCE

PRIMARY: _____ NUMBER: (  ) _____

POLICY ID: _____ GROUP: _____

GUARANTOR NAME: _____ DOB: _____

RELATIONSHIP: _____

2ND INS: _____ NUMBER: (  ) _____

POLICY ID: _____ GROUP: _____

GUARANTOR NAME: _____ DOB: _____

RELATIONSHIP: _____

## EMERGENCY CONTACTS

NAME: _____ NUMBER: (  ) _____

NAME: _____ NUMBER: (  ) _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PHARMACY: _____

LAB: _____

BAY ARTHRITIS
INSTITUTE

## FINANCIAL POLICY & GUARANTEE OF PAYMENT FOR SERVICES

Thank you for allowing us to be part of your health care team. In order for us to provide the best possible care and to maximize your medical insurance policy coverage, you must provide accurate insurance information. This includes providing current insurance card(s) and informing our staff of any recent changes, including employment, coverage, or address.

In the interest of providing you with uninterrupted quality medical care, we are advising you of the following:

- The relationship you have with your insurance company and employer is a contract of which we are not part. As a courtesy, our billing staff will process your claims for you, and answer any questions you may have. Please be advised that, regardless of your insurance status, final responsibility for payment of our services is your obligation.
- There are some insurance companies that require an authorization before an office visit will be paid; others have their own insurance guidelines about when a visit to a specialist's office will be covered. **It is your responsibility to know the extent of your insurance benefits and to get any required authorizations in advance of being seen.**
- We will make every attempt to notify you of your insurance coverage for our services. However, we cannot guarantee coverage for every service. Certain services, such as injections, test and mediations may not be covered by your insurance.
- Co-payments are due at the time of service. If you cannot pay the co-payment today, please notify the receptionist.
- If, for any reason, your insurance company chooses not to cover your office visit or any procedures, you will be responsible for payment at the time of service. This includes all future visits. The estimated cost for a visit can be provided to you in advance.
- Your signature below indicates that you will be responsible for payment in full should you fail to obtain an authorization, or should your insurance company choose not to pay for your visit.
- You authorize the release of any medical information to Advanced Rheumatology that may be necessary to process an insurance claim and authorize payment of medical benefits be made to Advanced Rheumatology for services rendered.

**I, _____, have read and agree with the above statement, and further agree to be responsible for all charges incurred, or to provide written approval authorization from my insurance company for all visits and procedures prior to being seen.**

_____ _____

Patient Signature Date

_____ _____

*Parent/Guardian/Guarantor Signature (if applicable)* Date

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**REASON FOR VISIT:** _____

**WHEN DID SYMPTOMS BEGIN:** _____ **LEVEL OF PAIN FROM 1-10:** _____

**PREVIOUS TREATMENT(S):** _____

**DRUG ALLERGIES:** ☐ YES ☐ NO IF YES, PLEASE LIST BELOW.

NAME _____ REACTION _____

NAME _____ REACTION _____

**CURRENT MEDICATIONS:**

| MEDICATION NAME | DOSAGE | FREQUENCY | FOR HOW LONG? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*CONTINUE ON THE BACK OF THIS PAGE IF MORE ROOM IS NEEDED.

**MEDICAL HISTORY:**

- ☐ ANXIETY DISORDER
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTOIMMUNE DISEASE
- ☐ BACK PROBLEMS
- ☐ BLEEDING DISORDER
- ☐ CANCER
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ EPILEPSY/SEIZURES
- ☐ FIBROMYALGIA
- ☐ HIV/AIDS
- ☐ HEAD TRAUMA/INJURY
- ☐ HEADACHES/MIGRAINES
- ☐ HEART DISEASE
- ☐ HEPATITIS
- ☐ HIGH CHOLESTEROL
- ☐ HYPERTENSION
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ LUPUS
- ☐ OSTEOPOROSIS
- ☐ STOMACH ULCER
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ TUBERCULOSIS
- ☐ OTHER: _____
- ☐ OTHER: _____

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**FAMILY HISTORY:**

- ☐ ANKYLOSING SPONDYLITIS
- ☐ AUTOIMMUNE DISEASE
- ☐ GOUT
- ☐ JUV. CHRONIC ARTHRITIS
- ☐ LUPUS
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ PSORIATIC ARTHRITIS
- ☐ RHEUMATOID ARTHRITIS
- ☐ OTHER: _____

PLEASE INDICATE FAMILY MEMBER(S).

FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____
FAMILY MEMBER: _____

**SURGICAL HISTORY:**

PLEASE INDICATE DATE OF SURGERY.

- ☐ APPENDECTOMY _____
- ☐ BREAST SURGERY _____
- ☐ CAESAREAN SECTION _____
- ☐ CATARACT SURGERY _____
- ☐ CHOLECYSTECTOMY _____
- ☐ COLONOSCOPY _____
- ☐ ENT/SINUS SURGERY _____
- ☐ GENERAL SURGERY _____
- ☐ HEART SURGERY _____
- ☐ HYSTERECTOMY _____
- ☐ ORTHOPEDIC SURGERY _____
- ☐ SPINAL SURGERY _____
- ☐ THYROID SURGERY _____
- ☐ TONSILLECTOMY _____
- ☐ TUBAL LIGATION _____
- ☐ OTHER: _____

**SOCIAL HISTORY:**

PLEASE CIRCLE YOUR ANSWER.

ALCOHOL INTAKE: NONE OCCASSIONAL MODERATE HEAVY

ANIMAL EXPOSURE: YES NO

CAFFEINE INTAKE: NONE OCCASSIONAL MODERATE HEAVY

CHEWING TOBACCO: 1/DAY 2-4/DAY 5+/DAY

EXERCISE LEVEL: NONE OCCASSIONAL MODERATE HEAVY

STRESS LEVEL: LOW MEDIUM HIGH

ILLICIT DRUG USE: YES NO

SMOKING STATUS: CURRENT NEVER A SMOKER FORMER

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**PAST MEDICATIONS:**

**NSAIDS** — YEAR

- ☐ ANSAID (flurbiprofen) _____
- ☐ ARTHROTEC (diclofenac/misoprosil) _____
- ☐ ASPIRIN _____
- ☐ CELEBREX (celecoxib) _____
- ☐ DAYPRO (oxaprozin) _____
- ☐ DOLOBID (diflusinal) _____
- ☐ FELDENE (piroxicam) _____
- ☐ INDOCIN (indomethacin) _____
- ☐ LODINE (etodolac) _____
- ☐ MOBIC (meloxicam) _____
- ☐ MOTRIN (ibuprofen) _____
- ☐ NAPROSYN (naproxen) _____
- ☐ ORUVAIL (ketoprofen) _____
- ☐ VOLTAREN (diclofenac) _____
- ☐ OTHER: _____ _____

**PAIN RELIEVERS**

- ☐ ACETAMINOPHEN (Tylenol) _____
- ☐ CODEINE (Tylenol 3) _____
- ☐ HYDROCODONE (lortab,norco, vicodin) _____
- ☐ ULTRAM/ULTRACET (tramadol) _____

**BIOLOGICS**

- ☐ ACTEMRA (tocilizumab) _____
- ☐ CIMZIA (certolizumab) _____
- ☐ ENBREL (etanercept) _____
- ☐ HUMIRA (adalimumab) _____
- ☐ KINERET (anakinra) _____
- ☐ ORENCIA (abatacept) _____
- ☐ REMICADE (infliximab) _____
- ☐ RITUXAN (rituximab) _____
- ☐ SIMPONI (golimumab) _____

**VISCOSUPPLEMENTATION**

- ☐ ORTHOVISC _____
- ☐ EUFLEXXA _____
- ☐ SUPARTZ _____
- ☐ SYNVISC _____

**CORTICOSTEROIDS** — YEAR

- ☐ DECADRON (dexamethasone) _____
- ☐ MEDROL DOSE PACK _____
- ☐ PREDNISONE _____
- ☐ CORTISONE INJECTION _____

**DMARDS**

- ☐ ARAVA (leflunomide) _____
- ☐ ATABRINE (quinacrine) _____
- ☐ AZULFIDINE (sulfasalazine) _____
- ☐ CELLCEPT _____
- ☐ CYTOXAN (cyclophosphamide) _____
- ☐ IMURAN (azathioprine) _____
- ☐ METHOTREXATE _____
- ☐ CYCLOSPORINE A _____
- ☐ PLAQUENIL (hydroxychloroquine) _____

**GOUT MEDICATIONS**

- ☐ ZYLOPRIM (allopurinol) _____
- ☐ COLCRYS (colchicine) _____
- ☐ BENEMID (probenecid) _____
- ☐ ULORIC (febuxostat) _____
- ☐ KRYSTEXXA (pegloticase) _____

**OSTEOPOROSIS MEDICATIONS**

- ☐ ACTONEL (risedronate) _____
- ☐ BONIVA (ibandronate) _____
- ☐ ESTROGEN (premarin, etc) _____
- ☐ EVISTA (raloxifene) _____
- ☐ FORTEO (teriparatide) _____
- ☐ FOSAMAX (alendronate) _____
- ☐ MIACALCIN (calcitonin) _____
- ☐ PROLIA (denosumab) _____
- ☐ RECLAST (zoledronic acid) _____

**FIBROMYALGIA**

- ☐ LYRICA (pregabalin) _____
- ☐ NEURONTIN (gabapentin) _____
- ☐ SAVELLA (milnacipran) _____

2232 W. 24th Street ■ Panama City, FL 32405 ■ WWW.BAYARTHRITIS.COM ■ 850-215-3062 ■ Fax: 850-215-3024

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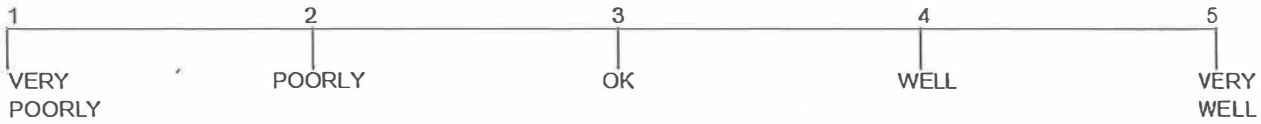
## ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ☐ Yes ☐ No If yes, how many? _____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____ Who does most of the yard work? _____

On the scale below, circle a number which best describes your situation; *Most of the time, I function…*




Because of health problems, do you have difficulty:
(Please check the appropriate response for each question.)

| | Usually | Sometimes | No |
|---|---|---|---|
| Using your hands to grasp small objects? (buttons, toothbrush, pencil, etc.) | ☐ | ☐ | ☐ |
| Walking? | ☐ | ☐ | ☐ |
| Climbing stairs? | ☐ | ☐ | ☐ |
| Descending stairs? | ☐ | ☐ | ☐ |
| Sitting down? | ☐ | ☐ | ☐ |
| Getting up from chair? | ☐ | ☐ | ☐ |
| Touching your feet while seated? | ☐ | ☐ | ☐ |
| Reaching behind your back? | ☐ | ☐ | ☐ |
| Reaching behind your head? | ☐ | ☐ | ☐ |
| Dressing yourself? | ☐ | ☐ | ☐ |
| Going to sleep? | ☐ | ☐ | ☐ |
| Staying asleep due to pain? | ☐ | ☐ | ☐ |
| Obtaining restful sleep? | ☐ | ☐ | ☐ |
| Bathing? | ☐ | ☐ | ☐ |
| Eating? | ☐ | ☐ | ☐ |
| Working? | ☐ | ☐ | ☐ |

BAY ARTHRITIS
INSTITUTE

## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY AUTHORIZE BAY ARTHRITIS INSTITUTE TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES PERFORMED WITHIN THEIR OFFICE OR BY THEIR ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO BAY ARTHRITIS INSTITUTE. I CERTIFY THAT THE INFORMATION I HAVE REPORTED, WITH REGARD TO MY INSURANCE COVERAGE, IS CORRECT.

PATIENT SIGNATURE: _____ DATE: _____

RELATIONSHIP, IF OTHER THAN PATIENT: _____

## FEES AND NOTICES

| | |
|---|---|
| $25 FEE FOR MISSED APPOINTMENTS | INITIALS _____ |
| $25 FEE FOR CANCELLATIONS WITHIN 24HRS | INITIALS _____ |
| $1/PAGE FOR MEDICAL RECORDS (UP TO 25PGS) | INITIALS _____ |
| $25 FEE TO COMPLETE PAPERWORK (UP TO 5PGS) | INITIALS _____ |
| RESULTS WILL NOT BE GIVEN OVER THE PHONE | INITIALS _____ |
| ALLOW 72HRS FOR MEDICAL RECORDS REQUESTS | INITIALS _____ |
| ALLOW 72HRS FOR PRESCRIPTION REFILLS | INITIALS _____ |
| NO NARCOTICS WILL BE GIVEN WITHOUT AN APPOINTMENT | INITIALS _____ |
| MEDICATION CHANGES REQUIRE AN APPOINTMENT | INITIALS _____ |
| ALL PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED | INITIALS _____ |
| BALANCES MUST BE PAID BEFORE YOUR NEXT APPOINTMENT | INITIALS _____ |

BAY ARTHRITIS
INSTITUTE

**AUTHORIZATION TO REQUEST AND RELEASE PROTECTED HEALTH INFORMATION**
**PLEASE FAX TO: (850) 215-3024**

PATIENT NAME: _____ DOB: _____

I AUTHORIZE: _____
TO RELEASE MEDICAL RECORDS TO THE PHYSICIAN/ENTITY LISTED ON THIS FORM.

PLEASE SEND:

- ☐ OFFICE NOTES _____
- ☐ LAB RESULTS _____
- ☐ IMAGING RESULTS _____
- ☐ INFUSION RECORDS _____
- ☐ MEDICATION LIST _____
- ☐ DEMOGRAPHICS _____
- ☐ ENTIRE CHART _____
- ☐ OTHER _____

OR

I AUTHORIZE BAY ARTHRITIS INSTITUTE/DR. AMIR AGHA TO RELEASE THE FOLLOWING MEDICAL RECORDS TO: _____

- ☐ OFFICE NOTES _____
- ☐ LAB RESULTS _____
- ☐ IMAGING RESULTS _____
- ☐ INFUSION RECORDS _____
- ☐ MEDICATION LIST _____
- ☐ DEMOGRAPHICS _____
- ☐ ENTIRE CHART _____
- ☐ OTHER _____

THE INFORMATION REQUESTED/RELEASED IS TO BE USED ONLY BY THE PHYSICIANS/ENTITIES NOTED ON THIS DOCUMENT FOR THE PURPOSE OF CONTINUITY OF MEDICAL CARE. I UNDERSTAND THAT I RESERVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND MUST DO SO IN WRITING. I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS FORM IN ORDER TO RECEIVE TREATMENT BY BAY ARTHRITIS INSTITUTE/DR. AMIR AGHA.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL THE DATE LISTED BELOW OR UNTIL THE PATIENT SUBMITS WRITTEN REVOKATION. EXPIRATION DATE: _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____
RELATIONSHIP TO PATIENT: _____ DATE: _____
WITNESS: _____ DATE: _____

BAY ARTHRITIS INSTITUTE

# 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.**

**THIS NOTICE TAKES EFFECT AUGUST 2014 AND REMAINS IN EFFECT UNTIL WE REPLACE IT.**

## 1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

## 2. OUR LEGAL DUTY

**Law Requires Us To:**

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

**We Have the Right To:**

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

**Notice of Change to Privacy Practices:**

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## 3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

***Facility Directory:*** Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, your location in our facility, your condition described in general terms, your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

***Notification:*** Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

***Disaster Relief:*** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

***Fundraising:*** We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not receive future fundraising communications.

***Research in Limited Circumstances:*** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

***Funeral Director, Coroner, Medical Examiner:*** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

BAY ARTHRITIS INSTITUTE

***Specialized Government Functions:*** Subject to certain requirements, we may disclose or use health information for military personal and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

***Court Orders and Judicial and Administrative Proceedings:*** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

***Public Health Activities:*** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

***Victims of Abuse, Neglect, or Domestic Violence:*** We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or escaped from legal custody.

***Workers Compensation:*** We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

***Health Oversight Activities:*** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or authorized activities.

***Law Enforcement:*** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. **YOUR INDIVIDUAL RIGHTS**

**You Have a Right To:**

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. If you request copies, we will charge you $1.00 for each page and postage if you want the copies mailed to you.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have a right to obtain a paper copy by making such a request in writing to the Privacy Officer at your office.

**QUESTIONS AND COMPLAINTS**

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

**I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT. A COPY WILL BE MADE AVAILABLE TO ME AT MY REQUEST.**

**PATIENT SIGNATURE:** _____ **DATE:** _____

**PRINTED NAME:** _____ **DOB:** _____