Natural Healing Ways

INTEGRATED MEDICINE AND ACUPUNCTURE

CLAUDIA WEITKEMPER

LAC, OMD, RN, NATUROPATH

1115 Marin Avenue
Albany, CA 94706
Phone: 510-978-3444
www.naturalhealingways.com
naturalhealingways@gmail.com

PATIENT INTAKE FORM

Date: ___________________

Personal Information

First Name *Last Name* *Date of Birth* *Sex* *Social Security Number*

Address *City* *State* *Zip Code* *Email*

(   ) ____________________

Phone 1 ☐ Home ☐ Mobile ☐ Work

☐ Single ☐ Married ☐ Widowed

Height ______'______" What is your normal weight range? _______-_______ *lbs.* How much do you weigh currently? _______*lbs.*

Insurance Information

Insurance Company *ID#* *Contact Number*

______________________________ / / ____________________ ☐ Spouse ☐ Dependent

Primary Insured Name *Date of Birth*

Reason For Visit

☐ New Patient ☐ Headaches ☐ Adjustment ☐ Back Pain ☐ Consultation

☐ Returning Patient ☐ Sciatica ☐ Injury ☐ Report of Findings ☐ Auto Accident

☐ Chronic Pain ☐ Menopause ☐ Other ____

Referred By/How Did You Hear About Natural Healing Ways?

☐ Provider/Insurance ☐ Friend/Family ☐ Web Search ☐ Walk In ☐ Other

Name of the person who referred you:____

Emergency Contact Information

Full name *Relationship*

Phone 1 ☐ Home ☐ Mobile ☐ Work

Complaints: List your chief complaint first

1. ______________________________ 2. ______________________________ 3. ______________________________

Does the pain travel anywhere else? If yes, where? ______________________________

Do you know what caused the problem? If yes, what? ______________________________

Do you notice the pain during a certain time of day? If yes, what time? ______________________________

Frequency: _______________	Times per	☐ Day	☐ Week	☐ Month	☐ Year
Duration: _______________	Pain Lasts	☐ Minutes	☐ Hours	☐ Days	☐ Other ___
Onset: Have had symptoms over the past		☐ Days	☐ Weeks	☐ Months	☐ Years
Intensity:		☐ Minimal	☐ Slight	☐ Moderate	☐ Severe
Is your condition:		☐ Better	☐ Worse	☐ Same	☐ Different

Rate your pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 being no pain at all and 10 being the worst imaginable

Type of pain, please describe:

☐ Aching	☐ Burning	☐ Cramping	☐ Deep	☐ Dull	☐ Numb
☐ Radiating	☐ Sharp	☐ Shooting	☐ Sore	☐ Stiff	☐ Tight
☐ Tingling	☐ Throbbing	☐ Swelling	☐ Stabbing	☐ Other: _______________	

Have you been given a diagnosis for this problem? If so, what was the diagnosis? ______________________________

____

What treatments have you tried for your condition?

☐ None ☐ Acupuncture ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Medication

Any other treatments? ______________________________

To ensure you receive a complete and thorough evaluation, please provide us with some important background information. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Please list your leisure activities: ______________________________

Please check any of the following caregivers whose care you're under now or have been under within the last 6 months:

☐ Medical Doctor (MD)	☐ Dentist	☐ Psychiatrist/Psychologist	☐ Chiropractor
☐ Osteopath	☐ Physical Therapy	☐ Homeopath	☐ Other: _______________

Date of last physical examination: _______________

If you have seen any of the above during the past three months please describe for what reason (illness, medical condition, physical, etc.): ______________________________

Have you EVER been diagnosed as having any of the following conditions? ***Please check if yes.***

☐ Cancer, if yes what kind? ______________________________

☐ Heart problems, if yes what kind? ______________________________

☐ High blood pressure

☐ Circulation problems

☐ Asthma

☐ Stomach ulcers

☐ Chemical dependency (i.e. alcoholism)

☐ Thyroid problems

☐ Diabetes

☐ Multiple Sclerosis

☐ Rheumatoid Arthritis

☐ Other arthritic condition

☐ Depression

☐ Hepatitis

☐ Tuberculosis

☐ Stroke

☐ Kidney disease, if yes what kind ____________________

☐ Blood clots

☐ Osteoporosis

☐ Other: ____________________

For Office Use Only

Other Information

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Have you ever been threatened, hurt, made to feel afraid or humiliated by your partner or someone close to you?

☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

Surgeries/Hospitalizations include date and reason:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains, and the approximate date of injury):

Date: _______ Injury: ______________________________

Date: _______ Injury: ______________________________

Date: _______ Injury: ______________________________

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:
Please check if yes.

☐ Yes Diabetes ☐ Yes Cancer ☐ Yes Alcoholism or chemical dependency
☐ Yes Stroke ☐ Yes Kidney disease ☐ Yes Inflammatory arthritis (Rheum./Anky.)
☐ Yes Depression ☐ Yes Heart disease ☐ Yes High blood pressure

If yes, who? ______________________________

List any medications, vitamins or herbs you are currently taking?

1. ____________________ 2. ____________________
3. ____________________ 4. ____________________
5. ____________________ 6. ____________________

If you consume caffeinated coffee or caffeine containing beverages, what time of day do you drink them and about how many ounces per day do you drink?

Amount: __________ Time of day: __________

Do you use tobacco? ☐ Yes ☐ No If yes, in what form do you use it (smoke/chew)? __________

How often and how much? __________ How long have you used it? __________

How many days per week do you drink alcohol? If one drink equals one beer, one glass of wine or one mixed drink how much do your normally drink at an average sitting?

Days per week: __________ Amount: __________ Type of alcohol: __________

Do exercise? If so, what do you average in a typical week?

Days per week: __________ Type of Exercise: __________ Minutes in Duration: __________

Meals:

What do you eat for breakfast ______________________________

What do you eat for lunch ______________________________

What do you eat for dinner ______________________________

Please note any of the following that are NEW, UNUSUAL, or ATYPICAL for you:

☐ Weight loss
☐ Nausea/vomiting
☐ Fever, chills, sweats
☐ Skin rash
☐ Difficulty breathing
☐ Dizziness/ light-headedness
☐ Numbness or tingling
☐ Joint/muscle swelling
☐ Heart racing in your chest
☐ Heartburn/indigestion
☐ Post menopause
☐ Pregnant (or think you might be)
☐ Weight gain
☐ Tremors
☐ Hearing problems
☐ Weakness
☐ Eye redness
☐ Night sweats
☐ Joint/muscle swelling
☐ Arm or leg swelling
☐ Joint/muscle swelling
☐ Blood in stools
☐ Urinary incontinence
☐ Stress at home or work
☐ Fatigue
☐ Double vision
☐ Sexual difficulties
☐ Easy bruising
☐ Seizures
☐ Problems sleeping
☐ Excessive bleeding
☐ Regular cough
☐ Constipation/diarrhea
☐ Problems urinating
☐ Blood in urine

Please indicate all of the following symptoms which reflect your situation.

General Symptoms

- ☐ Persistent pain at night
- ☐ Constant pain anywhere in body
- ☐ Unexplained weight loss
- ☐ Loss of appetite
- ☐ Unwarranted fatigue
- ☐ Dizziness
- ☐ Unusual lumps, nodules or growths
- ☐ Shortness of breath
- ☐ Pain or feeling of heaviness in chest
- ☐ Pulsating pain anywhere in body
- ☐ Constant/severe pain in lower leg or arm
- ☐ Discolored or painful feet
- ☐ Swelling unrelated to injury
- ☐ Frequent heartburn or indigestion
- ☐ Frequent nausea or vomiting
- ☐ Unusual menstrual abnormalities
- ☐ Frequent or severe abdominal pain
- ☐ Change in or problems with bladder function
- ☐ Fever or night sweats
- ☐ Recent severe emotional disturbance
- ☐ Swelling/redness in joints unrelated to injury
- ☐ Changes in hearing
- ☐ Frequent/severe headaches, unrelated to injury
- ☐ Problems swallowing
- ☐ Changes in speech
- ☐ Visual changes (blurriness, loss of sight, etc.)
- ☐ Problems with balance, coordination or falling
- ☐ Fainting spells
- ☐ Sudden weakness
- ☐ Body feeling hot
- ☐ Heat sensation in palms/soles of feet
- ☐ Low-grade fever in afternoon
- ☐ Low-grade fever at night
- ☐ Sweating at night
- ☐ Insomnia
- ☐ Dream disturbed sleep
- ☐ Nightmares
- ☐ Mental restlessness
- ☐ Dry mouth and/or throat
- ☐ Thirst
- ☐ Deep yellow urine
- ☐ Constipation
- ☐ Cold hands/feet
- ☐ Spontaneous sweating
- ☐ Asthma
- ☐ Shortness of breath when lying down
- ☐ Shortness of breath with exertion
- ☐ Diarrhea
- ☐ No energy
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Nausea
- ☐ Vomiting
- ☐ Sour regurgitation
- ☐ Abdominal distention
- ☐ Edema
- ☐ Vaginal discharge

Fei System Symptoms

- ☐ Nasal obstruction
- ☐ Watery nasal discharge
- ☐ Yellow/green nasal discharge
- ☐ Cough
- ☐ Hoarseness, if yes how long?:____________________
- ☐ Coughing up yellow/green sputum/phlegm
- ☐ Chills ☐ Coughing up sticky sputum/phlegm
- ☐ Body aches
- ☐ Coughing bloody sputum/phlegm
- ☐ Prone to catching flu/colds
- ☐ Acne
- ☐ Hives ☐ Itching of skin
- ☐ Eczema
- ☐ Rashes
- ☐ Allergies
- ☐ Blood in stool
- ☐ Mucus in stool
- ☐ Burning sensation of anus
- ☐ Dry Skin

Xin System Symptoms

- ☐ Feeling of constriction in chest
- ☐ Pain of heart region
- ☐ Heart palpitations
- ☐ Irregular heartbeat
- ☐ Listlessness
- ☐ Manic feeling
- ☐ Sore tongue
- ☐ Fidgetiness
- ☐ History of heart murmur
- ☐ Flushing of face
- ☐ Feeling of agitation
- ☐ Fainting

Pi System Symptoms

- ☐ General fatigue
- ☐ Poor appetite
- ☐ Craving particular foods
- ☐ Sudden drop of energy during the day
- ☐ Muscular weakness of limbs
- ☐ Bearing down sensation of stomach
- ☐ Indigestion
- ☐ Unusual bleeding
- ☐ Skin blotches
- ☐ Non-healing sores
- ☐ Always feeling hungry
- ☐ Feeling of stuffiness in stomach
- ☐ Burning sensation in stomach
- ☐ Bad breath
- ☐ Bitter taste in mouth
- ☐ Sticky saliva
- ☐ Gas
- ☐ Food allergies
- ☐ Regular bowel movements
- ☐ Not regular bowel movements
- ☐ Recent changes in bowel movement habits
- ☐ Hemorrhoids
- ☐ Frequency of bowel movements _____________ times per________
- ☐ Uterine bleeding
- ☐ Bleeding gums

Shen System Symptoms

- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Hair loss
- ☐ Problems with teeth
- ☐ Grinding of teeth
- ☐ Aversion to cold
- ☐ Achy bones
- ☐ Soreness of lower back
- ☐ Cold sensation in back
- ☐ Soreness /weakness of knees
- ☐ Frequent urination
- ☐ Clear, watery urination
- ☐ Prolapse of uterus
- ☐ Wake up to urinate ______ times per night
- ☐ Do not wake up to urinate
- ☐ Bed wetting
- ☐ Cloudy urine
- ☐ Urgency to urinate
- ☐ Dark yellow urine
- ☐ Burning of urethra
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Incontinence
- ☐ Infertility
- ☐ Loss of sexual desire
- ☐ Infertility

Gan System Symptoms

- ☐ Seizures
- ☐ Feeling of distention of head
- ☐ Headaches
- ☐ Vertigo
- ☐ Painful eyes
- ☐ Blurry vision
- ☐ Itchy eyes
- ☐ Cataract
- ☐ Glaucoma
- ☐ Color blindness
- ☐ Belching
- ☐ Churning feeling of stomach
- ☐ Muscle spasms
- ☐ Tremors of extremities
- ☐ Brittle finger/toenails
- ☐ Moodiness
- ☐ Sighing
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability

Gan System Symptoms (Cont.)

- ☐ Night blindness
- ☐ Nose bleeds
- ☐ Feeling of distention of abdomen
- ☐ Vomiting of blood
- ☐ Hiccups
- ☐ Easily susceptible to stress
- ☐ Ever been under care of counselor/psychiatrist
- ☐ Ever felt suicidal
- ☐ Ever attempted suicide

Three words which describe your emotions: ______________________________

Gynecological Information

Number of pregnancies: ______ **Live births** _____ **Premature births** ________ **Abortions** _______ **Miscarriages** ______

Are you pregnant now? ☐ Yes ☐ No ☐ Possibly

- ☐ I have regular cycles
- ☐ I do not have regular cycles
- ☐ I have painful periods
- ☐ Age of first period ___________

Length of cycle ________________________

Duration of cycle ______________________

Date of last GYN Exam______Results______

Date of last period _____________________

Do you experience any of the following with menstrual cycle?

- ☐ Breast Distention
- ☐ During cycle experience changing emotions
- ☐ Excessive bleeding
- ☐ Dark menstrual blood
- ☐ Menstrual blood with clots
- ☐ I do breast exams
- ☐ I do not use birth control
- ☐ Other ___________
- ☐ Before ☐ During
- ☐ Very scanty bleeding
- ☐ Watery menstrual blood
- ☐ Bleeding between periods
- ☐ I do not do breast exams
- ☐ My birth control of choice is: ______________________________

INFORMED CONSENT TO ACUPUNCTURE AND CARE

I hereby request and consent to the performance of acupuncture treatments, the prescription of herbal remedies and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible), by the acupuncturist named above and/or other licensed acupuncturists who now, or in the future, trat me while employed by, work with, and are associated with, or serve as a back-up for the acupuncturist named above, including those working at the clinic or office listed above or any office or clinic, whether signatories to this form or not.

I have been informed that acupuncture and herbal remedies have the effect of normalizing physiological functions and modifying pain, and are employed to treat certain diseases. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, slight bleeding or tingling near the needle site that may last for a few days.

I understand that only disposable needles are used in this clinic to minimize possible infections. There have been rare instances reported of fainting, infection or scarring. There have been extremely rare instances of reported spontaneous miscarriages, pneumothorax or death.

I have been informed that herbs are a safe method of treatment. However, I understand that herbal remedies occasionally may cause dizziness, nausea, vomiting, diarrhea, or constipation. Modifying or stopping the herbal remedy usually reverses these side effects. In extremely rare circumstances herbal remedies may cause irreversible damage and death.

I have had an opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture and herbal remedies. I understand that results cannot be guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgement on the best course of treatment based on the facts then known.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of my present condition and for any future condition(s) for which I seek treatment.

____________________________________ ________________________

Signature of Patient or Patient’s Representative Date signed.

____________________________________ ________________________

Print Name of Patient or Patient’s Representative Date signed

Release of Information to Process Insurance Claim

I hereby grant permission to the acupuncturist named and support staff to release all necessary information to my insurance company to process my insurance claim.

______________________________________ ______________

Signature of Patient or Patient’s Representative Date signed

Release of Information to Process Insurance Claim

I understand that unless I cancel my appointment at least 24 hours in advance. I will be charged the full amount for the missed appointment. I understand that my insurance will not cover these charges.

______________________________________ ______________

Signature of Patient or Patient’s Representative Date signed

Natural Healing Ways
INTEGRATED MEDICINE AND ACUPUNCTURE

CLAUDIA WEITKEMPER
LAC, OMD, RN, NATUROPATH

Lic. #AC-9000 / Tax ID #55-086-9333
1115 marin avenue, albany ca 94706
510.978.3444 | naturalhealingways@gmail.com

HIPAA 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 Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs.
(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements.
(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

Appointment Reminders

- Your health care provider or a staff member may disclose your health information to contact you to provide appointment reminders. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.
- You have the right to refuse us authorization to contact you to provide appointment reminders. If you refuse us authorization, it will not affect the treatment we provide to you.

Sign-in Log

This Practice maintains a sign-in log for individuals seeking care and treatment in the office. This sign-in sheet are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

Family/Friends

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Right to Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing.

Restrictions
You may request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment

You Have a Right to

Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Request copies of your PHI in electronic format if this office maintains your records in that format.

Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

Receive notice of any breach of confidentiality of your PHI by the Practice

Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

PRACTICE'S REQUIREMENTS

1. The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint.

Patient Signature:___________________________________ Date: ___________________