



# Neurology Consultants of Arizona

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Marital Status:  Married  Partnered  Single  Separated  Divorced  Widowed

Race/Ethnicity:  White  American Indian  Asian  Black/African American  Pacific Islander  Hispanic/Latino

Emergency contact: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Previous or referring doctor: \_\_\_\_\_

**EMPLOYER INFORMATION:**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer address: \_\_\_\_\_ Employer phone number: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE/GUARANTOR (If different than above):**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone number: \_\_\_\_\_ Address: \_\_\_\_\_

Check if patient is self-pay

**PRIMARY INSURANCE:**

Name of Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient/Member ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Employer: \_\_\_\_\_

**SECONDARY INSURANCE:**

Name of Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient/Member ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Employer: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directed to the physician. I understand that I am financially responsible for any balance. I also authorize Neurology Consultants of Arizona or insurance company to release any information required to process my claims.

I have also had an opportunity to review Neurology Consultants of Arizona's HIPAA patient privacy policies in the waiting room and have been given opportunity to receive a paper copy of these privacy policies should I desire them.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

**MEDICAL HISTORY:**





Patient name:

**Exercise-** Regular exercise is planned physical activity (e.g. brisk walking, aerobics, jogging, bicycling, swimming, etc.) performed to increase physical fitness. Such activity should be performed 4-5 times per week for 20-60 minutes per session. Exercise does not have to be painful to be effective but should be done at a level that increases your breathing rate and causes you to break a sweat.

Do you exercise according to the above definition?

Yes  No If yes, days per week: \_\_\_\_\_ Minutes per session: \_\_\_\_\_

**Alcohol-**

Do you drink alcohol?  Yes  No

If yes, what kind? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_

Have you ever felt the need to cut down on drinking?  Yes  No

Have you ever been annoyed by criticism of your drinking?  Yes  No

Have you ever felt the need for an eye-opener?  Yes  No

Have you ever experience black outs?  Yes  No

**Nicotine/Tobacco-**

Do you use or have you ever used nicotine products?  Yes  No

If yes, how much? \_\_\_\_\_pk/day Year quit: \_\_\_\_\_ Number of years: \_\_\_\_\_

Indicate type (cigarettes, chew, cigar, vaping. etc.) \_\_\_\_\_

**Safety-**

Do you have any concerns about physical, mental, or sexual abuse that you'd like to discuss with the physician?

Yes  No

**Mental-**

Do you feel depressed?  Yes  No

Have you ever seriously thought of hurting yourself?  Yes  No

Have you ever attempted suicide?  Yes  No

Have you ever been to a counselor?  Yes  No If yes, for what problem? \_\_\_\_\_

**FAMILY HISTORY:**

Does your family have a history of any of the following conditions?

Condition	Relationship	Condition	Relationship
Diabetes disease		Cancer (please indicate type)	
High blood pressure		Migraines	
High cholesterol		Alzheimer's/Dementia	
Kidney disease		Obesity	
Heart disease		Kidney disease	
Thyroid		Asthma	
Psychiatric disorder		Drug and/or alcohol abuse	

\*\*\*Please indicate if there is any other family or medical history that is not listed above you may feel is pertinent:

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Patient name:

<b>SYMPTOMS (now or in the recent past):</b>		
<p><b>Constitutional</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Insomnia</li> <li><input type="checkbox"/> Loss of appetite</li> <li><input type="checkbox"/> fevers</li> <li><input type="checkbox"/> Significant weight gain</li> <li><input type="checkbox"/> Significant weight loss</li> </ul> <p><b>Neurologic</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vision changes</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Memory loss</li> <li><input type="checkbox"/> Dizziness or vertigo</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Tingling</li> </ul> <p><b>Ear, Nose, Throat</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ringing in the ears</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Sinus- nose bleeds</li> <li><input type="checkbox"/> Oral lesions</li> <li><input type="checkbox"/> Neck or jaw pain</li> <li><input type="checkbox"/> Lumps in neck</li> </ul> <p><b>Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Sputum</li> <li><input type="checkbox"/> Coughed up blood</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Snoring</li> </ul>	<p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Swallowing problem</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Bloating</li> <li><input type="checkbox"/> Abdominal pain</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Irregular bowels</li> <li><input type="checkbox"/> Blood in stool</li> <li><input type="checkbox"/> Black stool</li> <li><input type="checkbox"/> Jaundice</li> <li><input type="checkbox"/> Hemorrhoids</li> </ul> <p><b>Genitourinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Menstrual trouble</li> <li><input type="checkbox"/> Menopause</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Urge to urinate</li> <li><input type="checkbox"/> Painful urinate</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Awakening to urinate</li> <li><input type="checkbox"/> Change in stream</li> <li><input type="checkbox"/> Lumps in testicles</li> </ul>	<p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain or pressure</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Wake up breathless</li> <li><input type="checkbox"/> Ankle swelling</li> <li><input type="checkbox"/> Leg cramping</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Cold feet or hands</li> <li><input type="checkbox"/> Passing out</li> </ul> <p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Joint pain</li> <li><input type="checkbox"/> Joint swelling</li> <li><input type="checkbox"/> Muscle aches</li> <li><input type="checkbox"/> Low back pain</li> </ul> <p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Change in moles</li> <li><input type="checkbox"/> Rash</li> </ul> <p><b>Hematology/Blood</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Easy bruising</li> <li><input type="checkbox"/> Gums bleeding</li> </ul>

# Neurology Consultants of Arizona

## MOTOR VEHICLE CRASH QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female | Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

DATE OF MOTOR VEHICLE CRASH: \_\_\_\_\_ Time of Day: \_\_\_\_\_

Have you retained an ATTORNEY?  Yes  No NAME: \_\_\_\_\_

Insurance Name of AT-FAULT VEHICLE: \_\_\_\_\_

AT-FAULT CLAIM #: \_\_\_\_\_ POLICY #: \_\_\_\_\_

Make/Model/Year of AT-FAULT VEHICLE: \_\_\_\_\_

Insurance Name of YOUR VEHICLE: \_\_\_\_\_

YOUR VEHICLE CLAIM #: \_\_\_\_\_ POLICY #: \_\_\_\_\_

Make/Model/Year of YOUR VEHICLE: \_\_\_\_\_

- Type of Accident:  Rear-End Collision  Head-On Collision  Broad-Side Collision
- Were you the:  Driver  Passenger |  Front Seat  Back Seat
- Was your vehicle moving at the time of the crash?  Yes  No | Estimated Speed \_\_\_\_\_ mph
- How fast was the AT-FAULT VEHICLE traveling at time of the crash? Estimated Speed \_\_\_\_\_ mph
- Were you surprised / unaware that the crash was going to occur?  Yes  No
- Did you brace for impact?  Yes  No | Were you wearing your seatbelt?  Yes  No
- What was the position of your headrest at the time of impact - TOP OF HEADREST AS REFERENCE  
 Even with the bottom of head  Even with the top of head  Even with the middle of head
- Position of your head at the time of impact?  Head turned | Looking  forward  back
- Do you recall striking your head or other body part at impact?  Yes  No | Describe: \_\_\_\_\_
- Did your airbag deploy?  Yes  No | Were the police notified?  Yes  No
- Were you taken by ambulance to the hospital?  Yes  No Hospital Name: \_\_\_\_\_
- Other medical care since the crash?  Yes  No Clinic Name(s): \_\_\_\_\_ Date(s): \_\_\_\_\_
- Have you received x-rays or other imaging since the crash?  Yes  No Location: \_\_\_\_\_

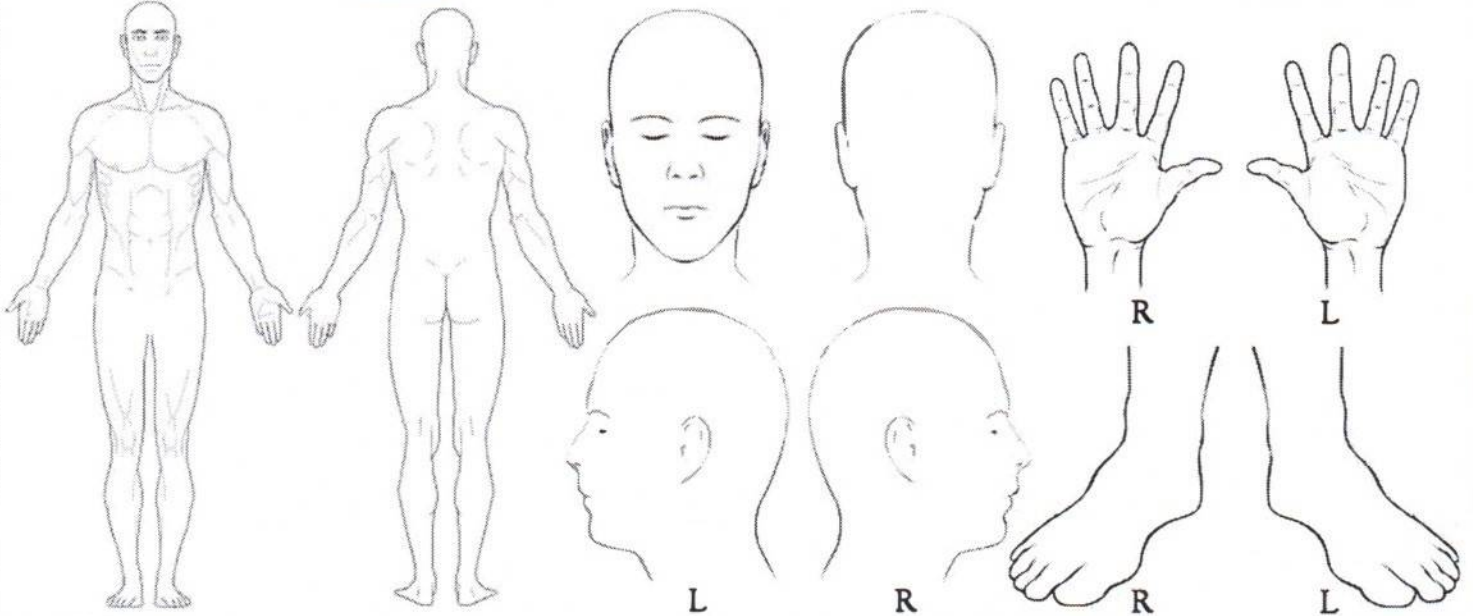
### CHECK INJURIES / SYMPTOMS APPARENT SINCE THE MOTOR VEHICLE CRASH:

- |  |   |                                       |   |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Visual Disturbance   | <input type="checkbox"/> Irritability | <input type="checkbox"/> Anxiety/Depression       |
| <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Arm Pain             | <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Lack of Coordination     |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Leg Pain             | <input type="checkbox"/> Lightheaded  | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder Pain        | <input type="checkbox"/> Ear Ringing  | <input type="checkbox"/> Difficulty with Walking  |
| <input type="checkbox"/> Hip Pain      | <input type="checkbox"/> Bowel/Bladder Issues | <input type="checkbox"/> Jaw Pain     | <input type="checkbox"/> Sleep Disturbance        |
- Bruising/Abrasions - Location(s): \_\_\_\_\_  OTHER: \_\_\_\_\_

# Neurology Consultants of Arizona

## MOTOR VEHICLE CRASH QUESTIONNAIRE (PAGE 2)

PLEASE MARK ALL AREAS OF COMPLAINT SINCE ACCIDENT



**MARK:** CIRCLE - AREAS OF PAIN, X - AREAS OF NUMBNESS,  
Z - AREAS OF TINGLING, W - AREAS OF WEAKNESS,  
C - BRUISING/CONTUSIONS/ABRASIONS

● Did you have any of the current physical complaints BEFORE THE CRASH?  Yes  No

If YES, Explain: \_\_\_\_\_

● Have you lost time from work as a result of this crash?  Yes  No

If YES, please complete: Last day worked: \_\_\_\_\_ Type of Employment: \_\_\_\_\_

If back to work - how many days did you miss? \_\_\_\_\_ How many days on light duty? \_\_\_\_\_

If working at this time, please complete:

\*If 0% is no capacity/unable to perform and 100% is full capacity (normal) with no restrictions,  
please list your % work ability since the auto crash: \_\_\_\_\_ %

● Please list THREE activities of daily living that have been affected since the crash (duties under duress):  
(for example: unable to play with kids, unable to drive, unable to do laundry, etc.)

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient name:

**OFFICE AND FINANCIAL POLICIES**

Welcome to Neurology Consultants of Arizona! It is our pleasure to provide you with excellent health care! Please take a few moments to read the following policies that will help us serve you better and make your visits more enjoyable.

**DEMOGRAPHICS/INSURANCE/PAYMENTS-** If your address, telephone number, or insurance changes, please notify us immediately. If your insurance changes it is your responsibility to verify that we are contracted with your new plan. Copays, deductibles, and coinsurances are due at the time of service and NO EXCEPTIONS will be made. There will be a \$40.00 fee for all NSF checks. If your account is sent to collections for failure to pay account balance when due, you will be charged a collection fee by our billing company in addition to the amount you owe on your account.

**APPOINTMENTS-** Please arrive 15 minutes prior to the time of your appointment. If you are more than 15 minutes late, we may ask you to reschedule (which may result in a charge) so that other patients are seen at their scheduled appointment times. You may be charged \$25.00 for office visits and \$150 for procedures if you miss an appointment or do not cancel or reschedule 24 hours prior to your appointment. If you miss three appointments in a 12-month period, you may be DISCHARGED from the practice.

**MEDICATIONS-** It is your responsibility to keep track of your medication supply. If you need an existing prescription refilled, please contact your pharmacy at least 3 DAYS ahead of time and they will contact us. Prescriptions will not be refilled after-hours or on weekends. PLEASE NOTE, many medications and all controlled substances require an appointment with your provider for refills so scheduling routine visits will be necessary if you are prescribed any of these medications. If it has been longer than one year since your appointment, you will need to schedule for medication refill.

**LABS AND REFERRALS-** Please allow 7-10 business days for most lab results. Labs take a few days to process at the labs themselves then the doctor must review the labs before signing off to the medical assistant. Please allow 7-10 business days for referrals but know that sometimes it may take longer due to getting approval on an authorized provider.

**MESSAGES-** Messages left for the doctors and/or medical assistants after 3:00pm and on weekends may not be returned until the next business day.

**FORMS-** An office visit is required for filling out forms by third parties such as disability insurance, worker's comp, FMLA, life insurance, motor vehicle accidents, etc to ensure accurate information.

**MEDICAL RECORDS-** There is an administrative fee of \$25 if you request a copy of your medical records, although faxing to another medical doctor is waived for continuation of care.

**GENERAL-** No food or drink, other than water, is to be consumed in the waiting or exam rooms. Minor children must be accompanied by a parent or legal guardian.

Thank you for your understanding; please acknowledge your acceptance of these policies by signing and dating below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient name:

HIPAA:

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Notice to patient:

We are required to provide you with a copy of Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I hereby acknowledge that I have been presented with a copy of Neurology Consultants of Arizona’s Notice of Privacy Practices. I authorize Neurology Consultants of Arizona and/or its employees to relay any and all communications regarding my lab results, medical testing, referral information, billing/account information, and any other pertinent health information in the following matter and to the following people:

Phone number: \_\_\_\_\_ May we leave a detailed message?  Yes  No  
Phone number: \_\_\_\_\_ May we leave a detailed message?  Yes  No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

Neurology Consultants of Arizona uses a secure HIPAA compliant email system to send confidential medical information. In addition, there is a secure internet e-mail portal; the web address is <https://patientportal.advancedmd.com/142331/account/logon>. The portal allows a secure two-way communication between clinical staff and patients. To access the portal, an e-mail address is required to sign up.

Email: \_\_\_\_\_

By signing below, I agree to the above and know that I may revoke this at any time by giving written notification to this provider.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only:** We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because

- The patient refused to sign
- Due to an emergency situation, it was impossible to obtain acknowledgement
- We weren’t able to communicate with the patient
- Other: \_\_\_\_\_

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_





Patient name: \_\_\_\_\_

**Authorization for the Release of Medical Records:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

The above named patient is hereby authorizing the release of medical information

To

From

Neurology Consultants of Arizona  
7425 E Shea Blvd. Suite 114  
Scottsdale, AZ 85260  
Phone: 480-977-6844 Fax: 480-977-6845

To

From

Facility or doctor name: \_\_\_\_\_  
Facility address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason: \_\_\_\_\_

The type of information to be disclosed is:

Complete medical records x 2 years

Progress note(s)

Lab report(s)

Pathology report(s)/Operative report(s)

Ancillary report(s) - imaging

Other: \_\_\_\_\_

**Release and Waiver:**

If the health information that I have requested Neurology Consultants of Arizona to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), human immunodeficiency (HIV), Venereal disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Neurology Consultants of Arizona and their provider and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

This authorization shall be considered invalid after 60 days. I may revoke this authorization at any time by providing Neurology Consultants of Arizona written notice or revocation. However, I may not revoke the authorization retroactively for information already released. I hereby waive all provisions of law and privilege relation to the disclosure hereby authorized.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Patient name:

## HIPAA Notice of Privacy Practices

Effective as of 6/1/2019

[Neurology Consultants of Arizona](#)  
[7425 E Shea Blvd. Suite 114, Scottsdale, AZ 85260](#)  
[P-480-977-6844 F-480-977-6845](#)

**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 of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

### **USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

**Other Permitted and Required Uses and Disclosures** will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may

Patient name:

not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

#### **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Luay Shayya, MD	480-977-6844	info@ncaz.org
HIPAA COMPLIANCE OFFICER	Phone	Email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Provided By HCSI– June /2019