Yeager Foot and Ankle Center

Patient Registration

Today's Date_____

Patient Information (Please use full legal name)

Last Name _____First Name_____ Middle Initial:_____

Date of Birth _____ Social Security: _____ Nickname (Name I preferred to be called)_____

Gender : ☐ male ☐ Female Martial Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

Physical Address_____ City_____ Zip code_____

Mailing Address_____ City_____ Zip code_____

☐Please mark box if the same as physical address

Email Address _____ Occupation:_____

Home Phone # _____ Mobile Phone # _____

Occupation _____ Work Phone #_____

Primary Care Physician _____ Date Last Seen: _____

Address:_____ City:_____ Zip Code:_____

Phone # _____

Preferred Pharmacy _____ Phone # _____

Do you currently have an active Workers Comp case?_____

Activities/Hobbies _____

Is there a caregiver needed for the patient?_____ Is transportation needed for the patient _____

Emergency Contact_____ Relationship to Patient_____ Contact #_____

Billing Information

Name of person responsible for this bill_____

Date of Birth _____ Social Security _____ Relationship to Patient_____

Occupation_____ Employer_____

Primary insurance Company_____ Subscriber Name _____

ID # _____ Group #_____ Policy # _____ Effective Date_____

Secondary insurance Company_____ Subscriber Name

_____

ID # _____ Group #_____ Policy # _____ Effective Date_____

Yeager Foot and Ankle Center

Last Name _____ First Name _____ Middle Initial: _____

Date of Birth _____ Age _____ Height _____ Weight _____ Shoe Size _____

Is your foot narrow or wide? _____ Have you purchased or been issued a DME product in the past 5 years? Yes/ No

Reason for Visit: _____

_____

_____

Duration: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years
Onset: ☐ Sudden ☐ Gradual
Course: ☐ Improved ☐ Worsened ☐ No Change
Nature: ☐ Numbness ☐ Burning ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Pressure

Time of Day _____ ◯ Right Foot ◯ Left Foot ◯ Both Feet Location _____

Improves with _____ Worsens with _____

Past Treatment: ☐ Insole ☐ Brace ☐ Injection

OTHERS _____

PAST FOOT/ ANKLE PROBLEM _____

_____

_____

STAFF ONLY

1. _____

_____

2. _____

_____

3. _____

_____

Yeager Foot and Ankle Center

Last Name _____ First Name _____ Middle Initial: _____

Date of Birth _____

List of Current Medications _____

_____

_____

Allergies: ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Darvocet ☐ Aspirin ☐ Adhesive/Tape ☐ Ibuprofen
☐ Local Anesthetic (Lidocaine, Marcaine) ☐ OTHERS PLEASE LIST _____

General Health

- ◯ Anemia
- ◯ Arthritis
- ◯ Artificial Joint/ Implants
- ◯ Atherosclerosis
- ◯ Bleeding Disorder
- ◯ Blood Pressure: High / Low
- ◯ Cancer: Type_____
- ◯ Dementia/Cognitive impairment
- ◯ Diabetes: Insulin Yes/ No Years:_____
- ◯ Gout
- ◯ Heart Disease
- ◯ Heart Valve: Implants/ Disease
- ◯ Hepatitis: A/ B/ C
- ◯ History of Infection
- ◯ Hormones Problem
- ◯ Kidney Problems
- ◯ Liver Disease
- ◯ Lung Disease/ Asthma
- ◯ Neurological Disease
- ◯ Neuropathy
- ◯ Psoriasis
- ◯ Rheumatic Fever
- ◯ Rheumatoid Arthritis
- ◯ Stroke
- ◯ Thyroid Problem
- ◯ Ulcer (Stomach)
- ◯ Unexplained Weight
- ◯ Vascular (Circulation)

Family History

- ◯ Arthritis
- ◯ Bleeding Disorder
- ◯ Blood Pressure: High/ Low
- ◯ Bunion
- ◯ Cancer: Type_____
- ◯ Diabetes: Insulin Yes/ No
- ◯ Heart Disease
- ◯ HIV Positive/ Aids
- ◯ Neurological Disease
- ◯ Vascular (Circulation)

Social History

Tobacco use: Yes/ No
How often:_____

Alcohol use: Yes/ No
How often:_____

Drug use: Yes/ No
How often:_____

Disabilities

Is there a Wheelchair, walker, or cane needed to ambulate?
Yes/ No

Do you need information for assistance in your home? Yes/No

Surgeries/ Hospitalization

Date:_____
Procedure:_____
_____
_____
_____
Anesthesia (Type):
_____

Date:_____
Procedure:_____
_____
_____
_____
Anesthesia (Type):
_____

I understand that completing this paperwork I have provided is true to the best of my knowledge. I recognized that the information I have provided will help me receive better care.

Patient/Authorized Representative (if applicable)_____ Date_____

Yeager Foot and Ankle Center

Appointment Cancellation/ No Show Policy

Our goal is to provide quality individual medical care in a timely manner. "No show" and late cancellations inconvenience those individuals who need medical treatment.

As a courtesy, you will receive an automated call, email or text message two (2) days in advance to confirm your appointment. We will leave a message on a voicemail if you are unable to be reached. If you are not able to keep your appointment, we will be happy to reschedule it for you.

Please give us a 24 – hour notice to cancel or reschedule your appointment. Appointments are in high demand, and your early cancellation will give another person the possibility to received medical care in a timely manner.

Failure to give a 24-hour cancellation or being a no show will result in a nonrefundable charge of $50.00. This fee will not be covered by insurance. You will receive a paper notice in the mail from our clinic to let you know that you have a no show charge.

If you have any questions regarding the policy, please ask our staff and we will gladly clarify your questions. We thank you in advance for your cooperation and understanding.

Financial Policy

We will bill Medicare and/or your private insurance for you. We are not a Medi-Cal provider. You are responsible for the deductible, co-insurance and non-covered services. We appreciate payment in full at each visit unless we are billing your insurance for you. In this case, the balance is due immediately following your statement. If your carrier has not paid within a reasonable period after the billing, you are responsible for payment in full. We are happy to discuss a payment/financial plan with you if you feel you are unable to make payment in full.

Insurance Authorization

I hereby give authorization for payments of insurance benefits to be made to Yeager Foot and Ankle Center and any assisting physicians, for the services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. I understand my signature requests that payment be made and authorize release of medical information if necessary to secure the payment of benefits. In the event of default, I agree to pay all costs of collection. I further agree that a photocopy of this agreement shall be as valid as the original.

By signing, I have read and acknowledge the Cancellation/ No Show Policy, Financial Responsibility and Insurance Authorization.

_____ _____

Patient Name (signature) Date

_____

Patient or Authorized Representative (if applicable)

Yeager Foot and Ankle Center

Peripheral Arterial Disease (PAD) Questionnaire

Patient Information (Please use full legal name) **Today's Date:**_____

Last Name _____First Name_____Middle Initial_____

Date of Birth _____ Age_____ Gender_____

Answers to the following will help determine if you are at risk for PAD and it a vascular examination can help better assess your vascular health status.

1. Do you experience any pain in your legs or feet while at rest?	◯ Yes ◯ No
2. Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/ exercising?	◯ Yes ◯ No
If yes to question 2, does the pain go away when you stop walking/ exercise?	◯ Yes ◯ No
3. Do your feet get pale, discolored or blush at any time during the day?	◯ Yes ◯ No
4. Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	◯ Yes ◯ No
5. Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication?	◯ Yes ◯ No
6. Do you have high blood pressure or take medication to reduce blood pressure?	◯ Yes ◯ No
7. Do you have Diabetes?	◯ Yes ◯ No
8. Do you have a history of chronic kidney disease?	◯ Yes ◯ No
9. Do you currently or have you ever smoked?	◯ Yes ◯ No
10. Do you have a history of stroke or mini stroke (TIA)?	◯ Yes ◯ No
11. Do you have a history of heart disease (heart attack, MI)?	◯ Yes ◯ No
12. Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm) and/or stent placement?	◯ Yes ◯ No

Patients and Care Team Partnership Agreement

Yeager Foot and Ankle Center has a strong tradition of excellence in patient care. We are committed to providing patient and family centered care along with the patient's participation. These expectations outline our partnership agreement which intended to provide compassionate care in an environment that promotes comfort, healing, and mutual respect between the patient and Care Team.

Expectations of the Patient and Care Team Partnership Agreement:

- Patient and Care Team (doctors, nurses, medical assistants, management, receptionist, etc.) will work together to provide the best possible care for the patient's progress during each visit.
- Patient will participate in cares necessary to encourage safe and timely discharge.
- Any rude, threatening, demanding comments or behaviors will be called out by the Care Team to the management team. Care will be terminated temporarily if the Care Team Member feels uncomfortable. Care will resume when respectful behavior is observed, and respectful communication is used. The Care Team will ask management to intervene if negative behaviors continue after request have been made to stop.
- Any physically threatening behavior demonstrated by the Patient will results in the intermediate termination of care.
- Families are welcomed and recognized as an important part of the patient's recovery. However, Yeager Foot and Ankle Center will not tolerate profanity, disruptive behavior, or any behavior that interferes with the care of any patient.
- Yeager foot and ankle center has a zero tolerance for any alcohol or drug use on the clinic property, abusive actions or language, or any other behavior that creates risk or threat to the patients, families, visitors, or the Care Team. Anyone, including families, violating our Zero Tolerance policy will be asked to leave the premises.

_____ _____

Patients Signature Date

_____ _____

Care Team Member Date

Yeager Foot and Ankle Center

429 REDCLIFF DR

SUITE 100

REDDING CA 96002

P. 530-244-0674 F. 530-244-1033

NEUROPATHY QUESTIONNAIRE

(Please circle YES or NO)

Does your pain have one or more of the following characteristics?

1. Burning YES or NO
2. Painful cold YES or NO
3. Electric Shocks YES or NO

Is the pain associated with one or more of the following symptoms in the same area?

1. Tingling YES or NO
2. Pins & Needles YES or NO
3. Numbness YES or NO
4. Itching YES or NO

Have you ever been Diagnosed with Neuropathy before?

YES or NO

Are you Diabetic?

YES or NO

Patient Name (Print) _____ Date _____

YEAGER FOOT AND ANKLE CENTER

429 REDCLIFF DR SUITE 100

REDDING CA 96002

P. 530-244-0674 F. 530-244-1033

Payment Policy

Thank you for choosing Yeager Foot and Ankle Center to provide you with all your Podiatry needs. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibilities for serviced rendered here at Yeager Foot and Ankle Center, we have been advised to develop this payment policy. Please read this policy and feel free to ask us any questions that you may have and sign in the space provided on the second page. A copy will be provided upon request.

1. **Insurance.** We participate in most insurance plans including but not limited to Medicare, BlueShield, Aetna, Cigna, and Tricare. We are **NOT in network with BlueCross or Anthem. Unless you have Medicare as primary insurance.** If you are not insured by a plan that we are not contracted with, payment in full is expected as each visit. You may pay as a cash pay patient, or you may try contacting your insurance company for possible in-network coverage. An addition form will need to be filled out if this is the case. If you are insured with an insurance company that we are contracted with you will need to make sure that you have a valid insurance card present along with a photo I.D. If you have an insurance that we are contracted with and do not have an up-to-date insurance card with you, you must pay in full with cash, check, or credit card until we can verify your insurance coverage. Knowing your own insurance plan and benefits is your responsibility. We do not sell or advertise insurance here at Yeager Foot and Ankle Center; we only provide medical attention. Please contact your insurance company with any questions or concerns that you may have.
2. **Co-payments and deductibles.** All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We do not pick your co-pay or deductible amount. Failure on our part to collect these payments from patients is considered fraud. Please help us in upholding the law by paying your dues at each visit.
3. **Non-covered services.** Please be aware that some and perhaps all the services rendered here at Yeager Foot and Ankle Center may or may not be covered by your insurance company. Each insurance plan is different. Podiatry is considered a Specialty care. Make sure that you understand what is and is not covered under your selected insurance plan. Some services may or may not be considered "Medically Necessary" to Medicare or other insurance companies. You are responsible for these services if they are not covered.
4. **Proof of insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a cop of your drivers license and current valid insurance information to provide proof of insurance. If you fail to provide us with the correct information (one) attempt will be made in order to obtain the correct information before you are responsible for the claim.
5. **Claims and submissions.** We will submit all your claims and assist you in any possible way that we can to help get your claims paid. Your Insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is solely your responsibility whether your insurance pays out or not.

YEAGER FOOT AND ANKLE CENTER

429 REDCLIFF DR SUITE 100

REDDING CA 96002

P. 530-244-0674 F. 530-244-1033

Your insurance benefits are contracted between you and your insurance company; we are not party to your contracts with your insurance company.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit here with Yeager Foot and Ankle Center so that we may make the appropriate changes to your account. If your insurance company does not pay your claim with in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due , you will receive a letter stating that you have up to 30 days to make a payment or set up a payment plan with the office manager. Please be aware that if your balance remains unpaid, we may send your account to an outsourced collections agency. In which case we can no longer assist you with your account balance.
8. **Missed appointments.** Our policy is to charge for missed appointments not cancelled within 24 hours. These charges will be your responsibility and will be billed directly to you in the mail. Please help us serve you and other to our maximum allowance by keeping your appointments.

Our practice provides the best treatment to our patients. Our prices are representative of the usual and customary charges for our immediate area.

Thank you for reading and understanding the payment policy. Please let us know if you have any questions or concerns.

I,_____ have read and understand that I will comply with Yeager Foot and Ankle Center's payment policy.

Patient signature _____ Date _____

SUSAN YEAGER, D.P.M.

NOTICE OF HIPAA PRIVACY PRACTICE

THIS NOTICE DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2017 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose your health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 of management of your health care with a third party. For example. We would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. 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.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with our health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommended for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of our appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves

the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent you.

Uses and Disclosures Based on Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Without your written authorization, we will not disclose your health information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative. A close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In additional, we may disclose your protected health information if we believe that you have been victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable products recalls; to make repair or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for the law enforcement authorities to identify or apprehend an individual.

SUSAN YEAGER, D.P.M.

NOTICE OF HIPAA PRIVACY PRACTICE

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example. We must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are following federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health 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 disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, and crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will not charge you for a paper copy. If you want X-Rays included there will be a charge of $10.00 for digital copy made within the office, if copies are requested of accrual film X-Rays there will be a charge of $40.00 to have then converted to digital.

By signing the form, I understand and have read the Notice of HIPAA Privacy Practice. A hard copy of the Notice of HIPAA Privacy Practice was given to me the patient as signed below.

Patient Name (Please Print)_____

Patient /Guardian Signature_____ Date_____

PATIENT'S COPY

SUMMARY OF HIPAA NOTICE OF PRIVACY PRACTICE

This summary is provided to assist you in understanding the attached HIPAA Privacy Practice

The attached Noticed of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to the Notice for further information.

Uses and Disclosures of Health Information

We will use and disclose your health information in order to treat you or to assist other health care providers to treating you. We will also use and disclose your health information in order to obtain payment for our services to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses of Disclosures Based on Your Authorization

Except as stated in more detail in the Notice of Privacy Practices, we will not use of disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care.
- For certain limited research purposes.
- For purpose of public health and safety.
- To government agencies for purposes their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist I apprehend to criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights

As our patient, you have the following rights:

- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request restrictions as to how your health information is used or disclosed.
- To request that we communicate with you in confidence.
- To request that we amend your health information.
- To receive notice of our privacy practices.

If you have questions, concerning or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

Accounting of Disclosures

You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatments, payment, health care operations and certain other activities.

Restriction Request

You have the right to request that we place additional restrictions on our disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request of additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

PATIENT'S COPY

SUMMARY OF HIPAA NOTICE OF PRIVACY PRACTICE

This summary is provided to assist you in understanding the attached HIPAA Privacy Practice

Confidential Communication

You have the right to request that we communication with you in confidence about your protected health information by alternative means or to an alternative location. You must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment

You have the right to request that we amend your protected health information. Your request needs to be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice

If you receive this notice on your website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed below to obtain this notice in writing.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to protect the privacy of your protected health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person	Office Manager
Telephone	(530) 244-0674
Fax	(530) 244-1033
E-mail	Footanklesx@gmail.com
Address	429 Redcliff Drive Suite 100 Redding, CA 96002