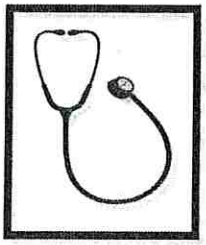
WELCOME TO DIAGNOSTIC CENTER OF MEDICINE



Lawrence M. Allen M.D.

Anthony Valiente APRN FNP-BC

Diagnostic Center of Medicine (Allen) LLP

Lawrence M. Allen, M.D.

Anthony Valiente FNP-BC

Office Policies

Patient Name: _____ Responsible Party: _____

Dear Patient,

To ensure that you receive the best possible medical service, we would like to inform you of some important office policies that you will need to be aware of. By becoming informed about our policies, you will be better prepared to take an active role in your health care experience.

- **Prescription Refills:** The easiest and most effective way for us to refill your locally obtained prescriptions is with your help. Please contact your pharmacy and request them to fax us a refill request. We then simply review the request, obtain your doctor's authorization, and either fax or electronically submit the approval back to your pharmacy. Please allow 48-72 hours for the process to be completed then call your pharmacy to verify that your prescription is ready. **(Note: Calling the office will not speed up the process.)** If you need written prescriptions for a mail-in pharmacy, please allow us 72 hours to prepare your prescriptions.
- **Test Results:** Due to the new HIPAA Privacy Act Laws, and also to ensure you receive accurate information, we are unable to divulge test results over the phone. If your doctor advises you to have testing, you must schedule a follow-up appointment to discuss the results directly with your physician. Note that if any of your testing shows a serious health problem or any results need to be reviewed, we will do our best to contact you to schedule an appointment at your earliest convenience.
- **Appointment Cancellations/No Show Fee:** Please be advised that if you fail to cancel an appointment with a 24-hour notice or if you fail to show up for your appointment without any notice, you may be charged a $25.00 fee. Also, note that failure to cancel or show up for Diagnostic Testing appointments may result in a higher fee.

I, _____ hereby agree to be financially responsible for all charges incurred, regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

I understand that some testing, such as lab tests, are ordered from and provided by facilities other than DCOM (for example Quest, Lab Corp, etc.) I also understand that in these cases, I will be billed by other organizations and that any questions concerning these charges are to be directed to that particular organization.

I understand that there will also be a $25.00 fee for all checks returned that are unpaid by my bank.

Thank you for your attention to these important office policies. Please sign on the line indicated below to signify that you have read and understand these procedures.

Respectfully,

DCOM Physicians & Staff

_____ _____

Patient Signature or Responsible Party Date

DIAGNOSTIC CENTER OF MEDICINE

☐ New Patient ☐ Established Pt.

DATE	PLEASE ENTER THE NAME OF THE DOCTOR SEEING YOU TODAY	PATIENT NUMBER

PATIENT INFORMATION

PATIENT NAME (LAST)	(FIRST)	(M.I.)	SSN:

HOME PHONE	SEX	DATE OF BIRTH	AGE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED	RACE ☐ CAUCASIAN ☐ AFRICAN-AMERICAN ☐ HISPANIC ☐ ASIAN ☐ OTHER

ADDRESS	APT / SPACE / UNIT #

CITY	STATE	ZIP

PATIENT'S EMPLOYER (Guarantor if patient is a minor or unemployed)	OCCUPATION

EMPLOYER'S ADDRESS	WORK PHONE

CITY	STATE	ZIP

GUARANTOR INFORMATION

GUARANTOR NAME (LAST)	(FIRST)	(M.I.)	SSN	HOME PHONE

GUARANTOR ADDRESS	CITY	STATE	ZIP

GUARANTOR EMPLOYER	OCCUPATION	WORK PHONE

GUARANTOR EMPLOYER ADDRESS	CITY	STATE	ZIP

E.M.D.

REASON FOR VISIT	REFERRING PHYSICIAN	HOW DID YOU HEAR ABOUT OUR OFFICE?

EMERGENCY

WHO TO NOTIFY IN CASE OF AN EMERGENCY	PHONE	RELATIONSHIP

ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION (Please have receptionist copy your insurance cards)

PRIMARY INSURANCE CO.	PHONE

ADDRESS	CITY	STATE	ZIP

POLICY HOLDER NAME	DATE OF BIRTH	SSN

RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER

POLICY #	GROUP #	EFFECTIVE DATE

SECONDARY INSURANCE CO.	PHONE

ADDRESS	CITY	STATE	ZIP

POLICY HOLDER NAME	DATE OF BIRTH	SSN

RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER

POLICY #	GROUP #	EFFECTIVE DATE

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor.

A copy of the signature is as valid as the original

Diagnostic Center of Medicine

CONFIDENTIAL MEDICAL HISTORY

Patient Name: _____

Record #: _____

Name: _____ Age: _____ Date: _____

Referred by (if any) _____

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space. Please leave no blanks.

GENERAL HEALTH AND HABITS

Characterize your present health status: Excellent ( ) Very Good ( ) Average ( ) Poor ( )

Exercise

Do you exercise regularly? Yes ( ) No ( )
How long have you exercised on a regular basis? ..... yrs.
Type of exercise(s) .....
How often .. .. days/week minutes each time

Smoking

Do you smoke? Yes ( ) No ( )
How many per day .....For how many years .....
What do you smoke? Cigarettes ( ) Pipe ( )
Cigars ( ) Other (specify) .....
When did you quit smoking? ..... years ago
How long have (had) you smoked? ..... years

Nutrition

Your weight: 10 years ago ..... 5 years ago ..... now ..
Your appetite: Excellent ( ) Good ( ) Fair ( ) Poor ( )
Are there foods you avoid (or limit) for health reasons? ?
Specify: .....

Alcohol/Beverage

Estimate the amount of alcohol you drink regularly:
..... drinks* per day .. .. drinks per week
Did you formerly drink alcohol but have permanently stopped?
Yes ( ) No ( )

Estimate the amount of caffinated beverages ALL you drink per day ..... glasses, cups, or cans

* one drink = 1 can beer, 4 oz. wine or 1 oz. hard liquor

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all the surgery you have had, indicating the nature of each operation and where and when it was done. (Be accurate and complete. Consult family, friends, physicians, etc.)

Operation	Hospital and City	Date

Have you ever been seriously injured? (If so, give details and date)

List chronologically all hospitalizations not already mentioned. (Do not include childbirth.)

Reason for Hospitalization	Hospital and City	Date

REVIEW OF SYSTEMS

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space.

Do not leave any blanks.

	No	Yes Date of Onset?	PHYSICIAN'S COMMENTS (leave blank)

RESPIRATORY

Have you ever had any of the following? (If so, indicate when)

- Pneumonia
- *Severe bronchitis*
- Pleurisy
- Tuberculosis skin test (Pos or Neg)
- Tuberculosis (infection or contact)
- Asthma (wheezing)
- Chronic bronchitis
- Emphysema
- Other lung trouble
- Exposure to dangerous dust or fumes
- Trouble breathing
- Excessive snoring
- Do you have chest pain
- Abnormal chest x-ray

Have you ever coughed up blood

Do you often or regularly

- Cough
- Raise sputum

Do you often get chest colds

When was your last chest x-ray

CIRCULATORY

Have you ever had any of the following? (If so, indicate when.)

- Chest pain
- Heart trouble
- Heart attack (coronary)
- Angina pectoris
- High cholesterol
- High blood pressure
- Blackouts
- Racing of heart
- Rheumatic fever
- Heart failure
- Abnormal electrocardiogram
- Swelling of your ankles

Have you ever taken heart or water pills?

ENDOCRINOLOGY

Have you ever had any of the following? (If so, indicate when.)

- Hormone problems
- Thyroid disease
- Diabetes
- Osteoporosis

	No	Yes Date of Onset?

DIGESTIVE

Do you often or regularly have?

- Poor appetite
- Trouble swallowing
- *Heartburn*
- Regurgitation of food or bile
- Nausea or vomiting
- Abdominal pain
- Constipation
- Diarrhea

Has there been any change in your bowel function in the last 6 mos.?

Have you ever had any of the following? (If so, indicate when)

- Hiatal or esophageal hernia
- Duodenal or gastric ulcer
- Vomiting of blood
- Black or tarry stools
- Blood in your stool
- Yellow jaundice
- Liver trouble or hepatitis
- Gallbladder trouble or stones
- Persistent diarrhea or colitis
- Diverticulitis
- Parasitis infection
- Hernia
- Other digestive disease

When was your last:

- Upper GI x-ray
- Barium enema x-ray
- Gallbladder x-ray/ultrasound
- UGI endoscopy (gastroscopy)
- Colonoscopy

JOINTS

Have you ever had any of the following? (If so, indicate when)

- Muscle pain
- Back pain
- Joint pain
- Joint swelling
- Gout

Has your doctor diagnosed arthritis, rheumatism?

CUTANEOUS

Have you ever had?

- skin rashes
- skin cancer

REVIEW OF SYSTEMS (continued)

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space.

Do not leave any blanks.

	No	Yes Date of Onset?	PHYSICIAN'S COMMENTS (leave blank)

URINARY

Have you ever had or been told you had any of the following? (If so, indicate when)

- Kidney disease or nephritis
- Protein or albumin in urine
- Blood or pus in urine
- Kidney stones
- Urinary infection
- Prostate trouble
- Syphilis or gonorrhea

How many times do you urinate:

- at night?
- during the day

Do you have discomfort passing urine?

Have you ever had a kidney x-ray (IVP)

OBSTETRIC & GYNECOLOGICAL

Have you ever had tumor(s), cyst(s), or other breast disease?

How many times have you been pregnant? (including miscarriages)?

How many live births?

Do you ever bleed ("spot") between periods or after intercourse?

At what age did you begin to menstruate?

Have you ever had toxemia?

Have you ever had a hysterectomy?

Are you now taking hormones or birth control pills?

When was your last Pap smear?

Have you had an abnormal Pap smear?

If you are still menstruating:

- Your last period?
- The one before?

How many days do your periods usually last?

Are your periods regular?

How heavy are they?

What is your cycle length?

If you had your change of life:

- When was your last period?
- Have you bled since?

SEXUAL

Are you having sexual difficulties?

HEMATOLOGY & ONCOLOGY

Have you ever had:

- Anemia?
- Bleeding or bruising tendency?
- Cancer or tumor?
- X-ray or radiation treatment

NEUROLOGOCAL

Have you ever had any of the following? (If so, indicate when)

- Neurological disease
- Frequent or recurrent headaches
- Loss of consciousness
- Convulsions or seizures
- Head injury
- Stroke
- Paralysis or muscular weakness
- Tremor or abnormal movements
- Difficulty with coordination
- Difficulty in walking
- Difficulty in speaking
- Double vision or loss of vision
- Numbness
- Difficulty with memory
- Dizziness

MOOD

Have you recently:

- Experienced severe anxiety, panic or phobias?
- Found it hard to concentrate?
- Felt unable to enjoy your usual activities?
- Had a weight change or eating disorder?
- Had insomnia or excessive daytime sleepiness?
- Thought yourself undeserving or worthless?
- Felt excessively fatigued?
- Felt depressed?

Have you ever had?

- A nervous breakdown or psychiatric care?
- A drug or alcohol problem?

Would you like consultation with a mental health professional?

SPECIAL SENSES

Have you ever had?

- Glaucoma
- Other major eye disease
- Deafness
- Abnormal noises in the ear

ALLERGY & IMMUNOLOGY

Have you ever had?

- Asthma
- Eczema or other skin problems
- Hay fever or stuffy nose/sinuses
- A reaction to penicillin
- A reaction to aspirin
- A reaction to any other drug

(Specify)

Date last immunized for	Year
Tetanus-Diphtheria (every 5-10 yrs.)	
Pneumococcal Pneumonia (Pneumovax)	
Influenza (Annual - Fall)	

CURRENT MEDICATIONS

List all the medications you are NOW taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list MUST be detailed, accurate, and complete; therefore consult with your family, druggist, physician. (Do not neglect aspirin and pain medicines; hormones; contraceptives, water, diet, nerve or sleeping pills.)

Name of medicine	Strength of each dose	How often taken	When began taking

PERSONAL HISTORY

Where were you born? _____

Have you ever lived or traveled extensively abroad? _____

(If so, give details) _____

What is your occupation? _____

Do you enjoy your work(retirement)? _____

List the areas you have lived in chronologically, giving dates:

Area	From	To

Have you ever worked in the field of medicine in any capacity (including volunteer, aide, clerk, technician)? _____

What is the highest level of education you have attained? _____

What inhaled chemicals or particles are you exposed to at your place of work? _____

List your past occupations chronologically, giving dates:

Occupation	From	To

FAMILY HEALTH

Please give the following information about the health of your immediate family:

Relation	Age if alive	Age at death	State of health or cause of death
Mother			
Father			
Brothers			
Sisters			
Spouse			
Children			

Have any blood relatives ever had any of the following? (If so, indicate relationship)

Diabetes	_____	Cancer (specify type if known)	_____		
Migraine	_____	Seizures or epilepsy	_____	Any obscure or unusual disease	_____
Allergies	_____	Blood disease	_____	Abnormal bleeding or clotting	_____
Alcoholism	_____	Psychiatric disease or suicide	_____	A disease which runs in the family	_____
Heart attack	_____	High blood pressure	_____	Kidney disease	_____

Signature of Patient _____

Patient Authorization for Release of Medical Information

Diagnostic Center of Medicine
Medical Records Department
5915 S. Rainbow Blvd, Suite 105, Las Vegas, NV 89118
Phone: 702-366-0640 Fax: 702-366-9672

Patient Name _____ Date of Birth _____ Last 4 of SS# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

I hereby authorize Diagnostic Center of Medicine, its affiliates, medical staff, employees, and their representatives to release my protected health information in the manner listed below, and to the following

Send by: _____ Mail _____ Fax _____ Secure Email

RECORDS FROM:

Name _____

Address, City, State, Zip _____

Phone _____ Fax _____ Email _____

SEND TO

Name _____

Address, City, State, Zip _____

Phone _____ Fax _____ Email _____

Choose One: All Records (Notes, Labs, Reports, CD) _____ Or _____ Specific Item Only (please List): _____

Depending on your request, it can take 2-3 weeks to receive records, though most requests are fulfilled sooner
This authorization will not expire except when revoked by patient, legal guardian, POA or health care surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written request to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once information is disclosed, it may be re-disclosed by the recipient and the information may not be protected under federal privacy law or regulations

Patients Name (printed) _____ Date of Birth _____

Patients Signature _____ Date _____

Opioid Treatment Agreement

*YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCES OF OPIOIDS *

You should be aware of potential side effects of opioids such as decreased reaction time, Clouded judgment, drowsiness, and tolerance. Also, you should know that the possible danger associated with the use of opioids while operating heavy equipment or driving.

SIDE EFFETCS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Sleepiness or drowsiness
- Problem with coordination or balance that may make it to operate dangerous equipment or motor vehicles
- Vomiting
- Breathing too slowly- overdose can stop your breathing and lead to death
- Aggravation or depression

*THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL *

Risks:

Physical Dependence: This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

- Runny nose
- Abdominal cramping
- Diarrhea
- "Goosebumps"
- Rapid Heart rate
- Difficulty sleeping for several days
- Sweating
- Nervousness

Psychological Dependence: This means it is possible that stopping the drug will cause you to miss it or crave it.

Tolerance: This means that you may need more and more of the drug to get the same effect.

Addiction: A small percentage of patients may develop addiction problems based on genetic or other factors.

Problems with pregnancy: If you are pregnant or contemplating pregnancy, discuss with your physician.

RECOMMENDEDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking. the medication dose, time of day you are taking them, their effectiveness, and any side affects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided into the days of the week and at times of the day so it is easier to remember when you take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand, no acute distress have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried as described above

Patients Signature _____ Physicians Signature _____ Date

FOLLOW UP PAIN FORM

Patient Name: _____
Last name, First name

Date of Birth: _____

What is your average pain score since your last office visit or procedure?

No Pain Pain at Max

1____2____3____4____5____6____7____8____9____10____

Have you has any new side effects from your pain medications?

_____ or _____
Yes No

What side effect(s) did you have?

____ Rash ____Insomnia ____Difficulty thinking clearly ____Slurred speech

____ Sleepiness ____ Difficulty seeing clearly ____Nausea/ Vomiting ____Poor Balance

____ Other: _____

Have you received any new medications from other physicians since your last visit?

_____ _____
Yes NO

If yes, what medication(s):_____

What is your present work status?

____ Regular. Full time ____ Regular, Part-time ____Not Working

If you work, how many days have you missed since your last visit?

___1 ___2 ___3 ___4 ___5 ___6 ___7 ___ 1 week plus

Have you been to an emergency room for pain since your last visit?

_____ _____
Yes No

Diagnostic Center of Medicine

Patient Name: _____ Responsible Party: _____

Dear Patient,

To ensure that you receive the best possible medical service, we would like to inform you of some important office policies that you will need to be aware of. By becoming informed about our policies, you will be better prepared to take an active role in your health care experience.

- Prescription Refills: The easiest and most effective way for us to refill your locally obtained prescriptions is with your help. Please contact your pharmacy and request them to fax us a refill request. When then simply review the request, obtain your doctor's authorization, and with fax or electronically submit the approval back to your pharmacy. Please allow 48-72 hours for the process to be completed. Then, call your pharmacy to verify that your prescription is ready. (Note: Calling the office will not speed up the process.) If you need written prescriptions for a mail-in pharmacy, please allow us 72 hours to prepare your prescriptions.
- Test Results: Due to the new HIPPA Privacy Act Law, and also to ensure you receive accurate information, we are unable to divulge test results over the phone. If your doctor advises you have testing, you must schedule a follow-up appointment to discuss the results directly with your physician. Please note that if any of your testing shows a serious health problem or any results need to be reviewed, we will do our best to contact you to schedule an appointment at your earliest convenience.
- Appointment Cancellations: Effective August 2003, DCOM instituted a cancellation/No Show Fee. Please be advised that if you failed to cancel an appointment without any notice, you may be charged a $25.00 fee. Also, please note that failure to cancel or show up for Diagnostic Testing appointments may result in a higher fee.

_____ hereby agrees to be financially responsible for all charges incurred, regardless of insurance coverage. In the event my account is referred to a collection service due to a lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

Initials____ I understand that some testing, such as lab test, are ordered from and provided by facilities other than DCOM (for example Quest, Lab Corp, ect.) I also understand that in these cases, I will be billed by other organizations and that any questions concerning these charges are to be directed to that particular organization.

Initial____ I understand that there will be a $25.00 fee for all checks returned that are unpaid by my bank.

Thank you for your attention to these important office policies. Please sign on the line indicated below to notify that you have read and understand these procedures

Respectfully,
Diagnostic Center of Medicine
Physicians & Staff

Diagnostic Center of Medicine

5915 S. Rainbow Blvd. Ste. #105

Las Vegas, NV 89118

702-366-0640 Phone

702-366-1655 Fax

Please Include Your Pharmacy Information:

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone/Fax: _____

Diagnostic Center of Medicine (Allen) LLP

Lawrence M. Allen, M.D.

Anthony Valiente FNP-BC

Medical Questionnaire

1. Have you ever had chest pain, chest tightness, a squeezing sensation in your chest, chest pressure or heaviness?	☐ Yes	☐ No
2. Do your ankles swell for no reason?	☐ Yes	☐ No
3. Do you get short of breath if you walk up a flight of stairs or if you exert yourself?	☐ Yes	☐ No
4. Do you get tired more easily, especially if you exercise?	☐ Yes	☐ No
5. Does your heart race or skip beats?	☐ Yes	☐ No
6. Do you get dizzy, light headed, or feel like you want to pass out?	☐ Yes	☐ No
7. Do you get short of breath when you lay down at night and have to use pillows to breathe better?	☐ Yes	☐ No
8. Do you get neck, jaw, or left shoulder pain when you exercise or exert yourself?	☐ Yes	☐ No
9. Have you ever had an episode of unexplained vision loss in your eyes?	☐ Yes	☐ No
10. Have you ever been told you have a heart murmur?	☐ Yes	☐ No
11. Has anyone in your family had a heart attack, heart bypass, angioplasty, heart failure, unexplained sudden death, or a stroke?	☐ Yes	☐ No

Thank you for filling out the questionnaire.
It will help your doctor better understand your medical history.

Your Name: _____ Date: _____

Diagnostic Center of Medicine
5915 S. Rainbow Blvd, Ste 105
Las Vegas, Nevada 89118
(702) 366-0640

Patient Printed Name: _____ Date of Birth_____

Patient Signature: _____ Date Signed_____

Consent for CareQuality/CommonWell Interoperability

(The electronic sharing of health-related data between two or more health organizations)

Please make your Consent selection here. The Consent Model will automatically apply a default status to all patients as defined below. If a patient would like a different consent selection, it can be chosen at the individual patient level.

Consent Model Options

- Opt-1 Patient clinical documents are automatically available for sharing. All patients consent statuses will be automatically set to "Opted In: Send and Receive Documents" with this model.
- Opt-2 Patient clinical documents are NOT automatically available for sharing. All patients consent statuses will be automatically set to "Opted Out" with this model. Any patient who expresses consent to share their data will need to be opted in on an individual level.

Patients have the following consent options available to them at the individual level. Please circle 1, 2, 3, or 4.

1. Opted In: Send and Receive Documents. eCW will send clinical documents when requested by external connected sites and will also request clinical documents from external connected sites and display them in eCW.
2. Opted In: Send Documents Only. eCW will send clinical documents when requested by external connected sites. eCW will not request any clinical documents from external connected sites.
3. Opted In: Receive Documents Only. eCW will request clinical documents from external connected sites and display them in eCW. eCW will not send any clinical documents to external connected sites.
4. Opted Out: NO SENDING. eCW will neither send clinical documents to nor request clinical documents from external connected sites.

Diagnostic Center of Medicine (Allen) LLP

Lawrence M. Allen, M.D.

Anthony Valiente FNP-BC

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 Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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 or 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Or 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 activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may disclose your protected health information to medical school students who 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.

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, and organ donation; research; criminal activity; military activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make disclosures to you and the Secretary of the Department of Health and Human Services, when required, to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this 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.

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information.

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 a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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 may have the right to have your physician amend 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 we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Administrative Office at 3012 S Durango Drive, Suite 2, Las Vegas, NV 89117, Phone (702)366-1655.

Your signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

I authorize my medical records to be accessed by the names listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____