AbsoluteQi Acupuncture & Wellness Center
Sunset Plaza • 710 Easton Avenue • Suite C • Somerset, NJ 08873 • 732-227-9991

Welcome to Our Office

Thank you for choosing AbsoluteQi for your health care. We will do everything we can to help you feel comfortable in our practice. If you have questions or concerns, please let us know so we can help you.

Patient Information
Keep this page for reference

PREPARING FOR YOUR VISIT

1. Your first visit includes a consultation followed by an acupuncture treatment. Allow 1 1/2 hours for your initial session and 45-60 minutes for follow-up sessions. This time may vary depending upon individual needs.
2. Please eat before you come for treatment, as it is undesirable to be treated on an empty stomach.
3. It is recommended, but not necessary, that you wear or bring loose-fitting, comfortable clothing that can easily be moved or removed to access acupuncture points. Women should not wear dresses in case points on the abdomen or back are used, although gowns are available for your comfort.
4. If you wear contact lenses that need to be removed when your eyes are closed for 20-30 minutes, please be prepared to take them out prior to your treatment.
5. Please refrain from wearing perfumes or colognes, as other patients who come to the office may be sensitive or allergic to fragrances.
6. Our office recommends that you see a physician &/or chiropractor for the condition you are presenting to our office before your initial visit for a diagnosis. If you plan to submit to insurance, please bring a written diagnosis & diagnostic code from your physician or chiropractor for our records.
7. We are not in network with any insurance carriers. For your convenience, if you have coverage, we will submit your claims and you will be reimbursed. Your insurance carrier may require a referral, letter of medical necessity, and/or preauthorization in order to receive applicable benefits. We recommend that you contact your carrier before your visit for an explanation of benefits.
8. All acupuncture needles are pre-sterilized and pre-packaged. They are used once and disposed of after each treatment.
9. Please turn off your cell phone when you enter the office, this will help you and other patients relax.

WHAT TO EXPECT

1. A review of your intake form and questioning about what you want treated with acupuncture.
2. Examination which may include tongue and pulse diagnosis and palpation of painful disorders.
3. An explanation of your condition.
4. An acupuncture treatment that is not painful, most people find acupuncture to be very relaxing.
5. Some patients will receive Chinese herbal, dietary and lifestyle recommendations.

AFTER YOUR TREATMENT

1. Drink a lot of water and relax.
2. Do not engage in strenuous activities immediately following your treatment.
3. You may feel energized, relaxed, or sleepy after your treatment.
4. You may feel muscular soreness after your treatment usually lasting about 24 hours, especially if you receive a muscular treatment including trigger point release.

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How to find us:

On this map 287 intersects with Easton Ave (527) to the left (West) and Rt 27 is to the right (East)

Enter the parking lot to Sunset Plaza on Bloomfield Ave., Go to the back of building into the 2nd parking lot. The office is the second one from the right when facing the back of the building

From Route 287:

- Take Exit 10/R-527/EASTON AVE.
- Follow signs on Easton Ave. toward New Brunswick
- Travel about 3 miles, Sunset Plaza, 710 Easton Ave. will be on the RIGHT
- Turn RIGHT onto Bloomfield Ave. and make RIGHT into parking lot

From Route 27:

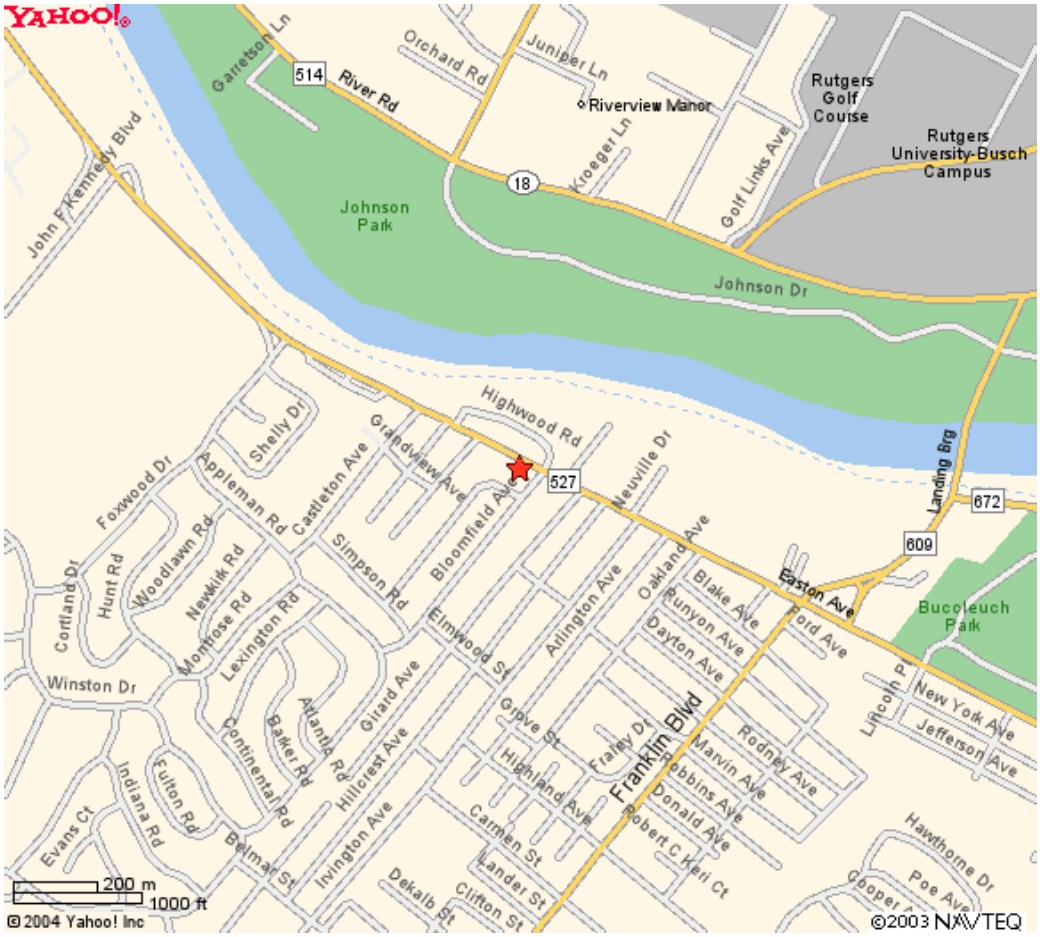
- Take Easton Ave. about 2 miles
- Turn LEFT onto Bloomfield Ave. and make RIGHT into parking lot.

From Route 18N:

- Take ramp toward EASTON AVE/SO BOUND BK.
- Turn SLIGHT RIGHT onto CR-672/GEORGE ST.
- at light Turn LEFT onto CR-609/LANDING LN.
- at light Turn RIGHT onto CR-527/EASTON AVE, travel less than a 1/2 mile
- Turn LEFT onto Bloomfield Ave. and make RIGHT into parking lot.

From 514 (Hamilton/Amwell Rd.):

- Take John F. Kennedy (JFK) Blvd 2.1 miles to Easton Ave.
- Turn RIGHT onto Easton Ave. travel 0.7 miles
- Turn Right onto Bloomfield Ave. and make RIGHT into parking lot.



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Acupuncture treatments are by appointment during the following hours:

	Morning	Evening
Monday		3:00 - 8:00 (7:00 last appt)
Tuesday	9:30 - 1:00 (12:00 last appt)	
Wednesday		3:00 - 8:00 (7:00 last appt)
Thursday	9:30 - 1:00 (12:00 last appt)	
Friday		
Saturday	8:00 - 12:00 (11:00 last appt)	
Sunday		

Patient Information
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Service & Fees

Payment is due upon receipt of services.

If your insurance covers acupuncture treatment, we would be happy to submit your claims electronically or we will provide you with a bill for reimbursement.

Acupuncture Cost:

Initial Consultation and Treatment	$135 and up
Follow-up treatments	$85 and up
Double treatments (front & back or extended trigger point acupuncture)	$125 and up
Re-evaluation (patient not seen in 6 months) and treatment	$125 and up

Adjunct therapies:

Moxibustion, Gua Sha, Cupping or Electric stimulation

combined with acupuncture	$25 and up
with no acupuncture treatment	$85

Cancellation Policy

We are a unique and small center. Our goal is to give you the time and attention that you need. Therefore, when you make an appointment, it is YOUR time.

We request that you honor a 24-hour cancellation policy so that other people have the opportunity for treatment if you are unable to attend your appointment.

Failure to notify our office in advance may result in a charge for a missed visit.

Thank you for your confidence and trust.
We will do our best to help you attain your goals in health.

Rhonda B. Hogan, L.Ac.
Licensed Acupuncturist

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Patient Information Confidential

Welcome to AbsoluteQi Acupuncture & Wellness Center

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. AbsoluteQi considers this information privileged physician/patient communication and will hold it in confidence.

Name (Last, First, Middle)				Date
Age	Date of Birth	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	

Phone	Cell Phone	Email Address

Home Address	Social Security Number (for insurance)	
City	State	Zip

Employed By	Occupation	
Employer's Address	Business Phone	
City	State	Zip

Spouse's Name	How did you find us?

Emergency Contact	Relationship	Phone

Additional Information / Notes

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by AbsoluteQi Acupuncture and Wellness Center is based upon Traditional Chinese Medical (TCM) principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese Medicine and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

Signature _____ Date _____

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Medical History

Confidential

Name (Last, First, Middle)	Date of Birth

Major Complaint/Health Problem

How did this condition develop?

How long has this condition persisted?

List anything that makes it better?

List anything that makes it worse?

Have you ever received treatment for this condition? ☐ Yes ☐ No	If yes, what kind(s) of treatment?
What was the diagnosis?	By Whom?
When?	Where?
What were the results of the treatment?	

List all substances that you are allergic to:

List all Medications that you are currently taking	For Condition	Strength	How many / day?	For how long

List any major surgeries you have had:

Date	Problem / Surgery

Significant Trauma (auto accidents, falls, etc.)

Significant Illnesses (Please check all that apply)

☐ Arthritis	☐ Connective tissue disease	☐ Hypertension	☐ Thyroid disease
☐ Asthma	☐ Diabetes	☐ Kidney stones	☐ Venereal disease
☐ Autoimmune disease	☐ Gallstones	☐ Rheumatic fever	☐ _____
☐ AIDS	☐ Heart disease	☐ Ruptured appendix	☐ _____
☐ Cancer	☐ Hepatitis	☐ Seizures	☐ _____

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Medical History

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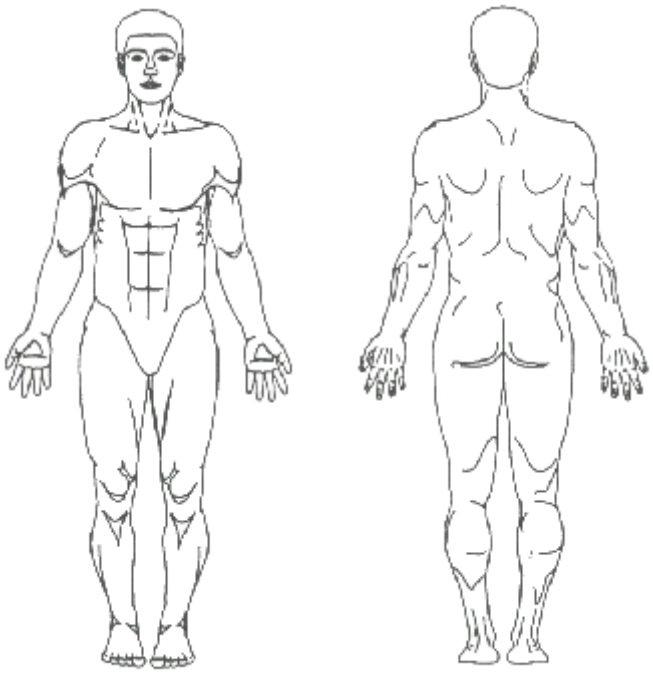
Name (Last, First, Middle)	Date of Birth

Please indicate all areas of discomfort and concern. Please be thorough.

Draw / mark whatever feels appropriate to how you feel. You may use color.



Comments/Notes:

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Health History

Confidential

Name (Last, First, Middle)	Date of Birth

Please check any symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Low energy
- ☐ Dizziness
- ☐ Allergies
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweat spontaneously
- ☐ Night sweating
- ☐ Lack of sweating
- ☐ Weight loss
- ☐ Weight gain
- ☐ Aversion to heat
- ☐ Aversion to cold

Head & Neck
- ☐ Blurred vision
- ☐ Heaviness in the head
- ☐ Headache
- ☐ Phlegm in throat
- ☐ Cataract
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Eye pain/strain
- ☐ Corrected vision
- ☐ Nasal obstruction
- ☐ Nasal discharge
- ☐ Loss of sense of smell
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Recurrent sore throat
- ☐ Red/inflamed eye
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sores on lips
- ☐ Sores on tongue
- ☐ Taste change
- ☐ Teeth problems
- ☐ Vision – see halos

Respiratory
- ☐ Asthma
- ☐ Hay fever
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Recurrent bronchitis
- ☐ Phlegm production
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Hypochondriac pain
- ☐ Distention in chest or hypochondrium

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Bloody stools
- ☐ Black stools
- ☐ Difficulty swallowing
- ☐ Heartburn/reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Poor appetite
- ☐ Stomachache
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood

Diet/Lifestyle
- ☐ Vegetarian
- ☐ Healthy diet
- ☐ Eat much fried foods
- ☐ Eat much meat
- ☐ Smoke cigarettes
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Use drugs
- ☐ Eat a lot of sweets
- ☐ Take melatonin
- ☐ Take steroids
- ☐ Exercise regularly
- ☐ Exercise excessively

Weight
- ☐ Underweight
- ☐ Normal for height
- ☐ Overweight
- ☐ Very overweight

Genitourinary
- ☐ Dilute urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Frequent urination
- ☐ Poor bladder control
- ☐ Urgency to urinate

Skin
- ☐ Thick skin
- ☐ Thin skin
- ☐ Broken blood vessels
- ☐ Blood not clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Dark circles around eyes
- ☐ Bags under eyes
- ☐ Lumps in groin
- ☐ Lumps underarm
- ☐ Dry skin
- ☐ Acne
- ☐ Brittle nails
- ☐ Premature gray hair
- ☐ Dry, brittle hair
- ☐ Hair falling out

Emotional
- ☐ Insomnia
- ☐ Irritability
- ☐ Often feel angry
- ☐ Troubling dreams
- ☐ Cry uncontrollably
- ☐ Feel sad a lot
- ☐ Forgetful
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Much fear
- ☐ Unrestrained joy
- ☐ Terrors
- ☐ Difficulty expressing emotions

Men Only
- ☐ Genital pain
- ☐ Impotence
- ☐ Genital sores
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Nocturnal emission
- ☐ Low sexual energy

Neurological
- ☐ Fainting
- ☐ Convulsions
- ☐ Handwriting change
- ☐ Paralysis
- ☐ Stroke
- ☐ Seizures
- ☐ Tremor
- ☐ Recent clumsiness
- ☐ Drowsiness
- ☐ Vertigo

Musculoskeletal
- ☐ Pain, weakness, numbness

Where:
- ☐ Arms
- ☐ Hands
- ☐ Joints
- ☐ Legs
- ☐ Feet
- ☐ Hips
- ☐ Neck
- ☐ Shoulders
- ☐ Pain all over
- ☐ Cold limbs
- ☐ Knee problems
- ☐ Low back pain
- ☐ All over weakness
- ☐ Lack of strength
- ☐ Broken bones

Women Only
- ☐ Abnormal pap smear
- ☐ Bleed between periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ <25 day cycle
- ☐ >35 day cycle
- ☐ Endometriosis
- ☐ Painful periods
- ☐ Premenstrual tension
- ☐ Breast lumps
- ☐ Contraceptives
- ☐ Sores on genitalia
- ☐ Low sexual energy
- ☐ Vaginal discharges
- ☐ Menopausal
- ☐ Uterine prolapse
- ☐ Facial hair
- ☐ Loss of head hair
- ☐ May be pregnant

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Consent For Chinese Medicine Treatment
Acupuncture Procedures and Herbal Recommendations

I, the undersigned patient (on behalf of the patient), hereby authorize Rhonda B. Hogan, L.Ac., to treat me by way of Chinese medical procedures, including, but not limited to acupuncture, moxibustion, electro-stimulation and herbal recommendations. I understand that Chinese medicine does not act as primary healthcare and the nature, consequences and benefits of these procedures have been explained to me sufficiently, completely and in detail and are reiterated below:

Acupuncture is a system of therapeutic treatment, which works on the body's energy pathways to resolve energetic imbalances. Acupuncture procedures involve the insertion of very fine, sterile needles into the surface of the body, but also may include moxibustion, cupping, electro-stimulation, manual pressure and other techniques used in the practice of Chinese Medicine.

Potential risks may include slight pain or discomfort at the site of needle insertion, bruises, weakness, fainting, nausea and possible temporary aggravation of symptoms. Occurrences of these situations are rare and can be minimized by proper nutrition and rest prior to the treatment, and by closely communicating any uncertainties with the acupuncturist before and during the treatment.

Potential benefits are enhanced by resting appropriately and following any recommendations made by the acupuncturist. Acupuncture may allow for painless and drugless relief of my symptoms and improved balance of bodily energies, which may lead to prevention, or elimination of the condition as well as other health benefits.

I understand that medical conditions require diagnosis by a licensed physician and my physician should monitor any change in prescribed pharmaceutical drug use. Chinese medicine is not offered as primary care in the State of New Jersey at this time, it is complementary healthcare therapy.

Signature of Patient (Guardian if minor)	Print Patient's Name
Attending Acupuncturist	Date

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Cancellation & Re-Scheduling Policy

We understand that there are times when you will need to cancel and/or reschedule your appointment. We are pleased to accommodate your needs. We request that you call two (2) days in advance.

It is our policy however, that all cancellations and/or rescheduling be done at least twenty-four (24) hours prior to your appointment time. (Except Monday appointments, which we require you cancel and/or reschedule by Saturday twelve noon.)

You will be charged 50% of the treatment amount if cancellation and/or rescheduling for your appointment is not done as noted above.

Showing-up for Your Appointment

We encourage you to arrive a few minutes before your appointment time.

We believe that treating patients at their scheduled time is a courtesy and a sign of respect. We work hard to minimize your wait and maintain our standard.

If you arrive late, it will affect our ability to keep our time commitment with other patients. Therefore, you may have to wait for an available time, we may need to shorten your treatment, or worst case we may not be able to accommodate you.

If your treatment is shortened due to your late arrival you will be charged 100% of the scheduled treatment amount.

If we cannot accommodate you due to your late arrival, you will be charged 50% of your scheduled treatment amount.

If you do not show up for your appointment, you will be charged 100% of the scheduled treatment amount.

We understand that under certain circumstances, there may be times you just can't keep an appointment. We will have to use our discretion when to waive a charge if you have not followed our policies. Examples of these may be death of a loved one, sudden illness / hospitalization of you or family member, or an accident. If you repeatedly arrive late or do not show, waived charges will not be considered.

Please sign below indicating that you understand and accept this policy:

_____
Print Patient's Name

_____ _____
Signature of Patient (Guardian if minor) Date

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

NO CONSENT REQUIRED

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

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

Patient Information
Keep this page for reference

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

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

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

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

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or
- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

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

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

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

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

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

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

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

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

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

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

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

Patient information
Keep this page for reference

Appointment Reminders

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

Family/Friends

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PRACTICE'S REQUIREMENTS
1. The Practice:

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

Patient Signature:_____ Date: _____