WILLIAM M. JACOBSEN, MD, FACS

COSMETIC & RESTORATIVE SURGERY

PATIENT INFORMATION

PATIENT NAME	SOCIAL SECURITY NUMBER	
MAILING ADDRESS	DATE OF BIRTH	GENDER ☐ FEMALE ☐ MALE
CITY STATE ZIP	HOME PHONE NO	CELL PHONE NO

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR E-MAIL?
☐ YES ☐ NO YOUR PREFERRED EMAIL ADDRESS PLEASE?
MAY WE LEAVE PERSONAL MEDICAL INFORMATION WITH TEXTS?
☐ YES ☐ NO YOUR PREFERRED CELL PHONE # PLEASE?

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICE MAIL?
☐ YES ☐ NO YOUR PREFERRED PHONE NUMBER PLEASE?

YOUR SIGNATURE :

HOW DID YOU HEAR ABOUT US? ☐ WEB SEARCH ☐ GOOGLE ☐ PHYSICIAN ☐ INSURANCE ☐ WORD OF MOUTH ☐ OTHER

WHAT IS THE REASON FOR TODAY'S VISIT?

IF PATIENT IS UNDER AGE OF 18

PARENT/GUARDIAN NAME	CONTACT NUMBER

ADDITIONAL CONTACT INFORMATION

ADDITIONAL AUTHORIZED CONTACT (FULL NAME & RELATIONSHIP)	CONTACT NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME ____	INSURANCE NAME ____
POLICY/ID#____	POLICY/ID#____
GROUP/ACCOUNT#____	GROUP/ACCOUNT#____
CARDHOLDERS NAME ____	CARDHOLDERS NAME ____
DOB ____ SS#____	DOB ____ SS#____
RELATION TO PATIENT ____	RELATION TO PATIENT ____

PHYSICIAN INFORMATION

NAME OF REFERRING PHYSICIAN		CONTACT NUMBER
PRIMARY CARE PHYSICIAN		CONTACT NUMBER
OTHER PHYSICIAN	SPECIALITY	CONTACT NUMBER
OTHER PHYSICIAN	SPECIALITY	CONTACT NUMBER
OTHER PHYSICIAN	SPECIALITY	CONTACT NUMBER

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Cosmetic & Restorative Surgery

PHARMACY INFORMATION

PHARMACY NAME	PHARMACY CROSS STREETS

ALLERGIES (PLEASE LIST ALL MEDICAL ALLERGIES)

☐ NKDA (NONE KNOW DRUG ALLERGIES)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?
LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING SUCH AS BLOOD THINNERS, VITAMINS, NATURAL HERBS OR DIET SUPPLEMENTS.

☐ ADVIL	☐ AGGRENOXX	☐ ALEVE	☐ BRILINTA
☐ COUMADIN	☐ EFFIENT	☐ FRAGMIN	☐ HEPARIN
☐ IBUPROFEN	☐ LOVENOX	☐ MOTRIN	☐ NAPROSYN
☐ ELIQUIS	☐ PLAVIX	☐ PRADAXA	☐ WARFARIN

PLEASE LIST ANY ADDITIONAL MEDICATIONS

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

HISTORY

DO YOU SMOKE ANY TOBACCO PRODUCTS AT ALL, EVEN OCCASIONALLY?	☐ YES ☐ NO
DO YOU HAVE A PAIN MANAGEMENT PHYSICIAN?	☐ YES ☐ NO
ETHNICITY ☐ HISPANIC ☐ NON-HISPANIC	RACE ☐ CAUCASIAN ☐ AFRICAN ☐ AMERICAN INDIAN ☐ ASIAN ☐ OTHER

DO YOU HAVE ANY MEDICAL PROBLEMS?

☐ ANGINA	☐ ASTHMA	☐ BLEEDING	☐ BREAST CANCER
☐ DIABETES	☐ HEART ATTACK	☐ HIGH BLOOD PRESSURE	☐ KIDNEY FAILURE
☐ LUNG DISEASE	☐ SEIZURES	☐ SKIN CANCER	☐ STROKE

PLEASE LIST ANY ADDITIONAL MEDICAL PROBLEMS

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

William M. Jacobsen, MD, FACS

Cosmetic & Restorative Surgery

LEGAL, ATTORNEY, INSURANCE OPINIONS, FORMS OR LETTERS

Dr. Jacobsen does not wish to disappoint you if the intent or any portion of the intent of your consultation is to obtain any of the following: opinion, medical expert, witness, letter or document related to legal claims, your lawyer's instructions or need for documentation related to any injury or surgery done elsewhere. Please inform our staff before you see Dr. Jacobsen so they can immediately help you find an alternative Plastic Surgeon for consultation. Dr. Jacobsen does not participate and will not engage in legal matters either during or after your consultation and will not communicate with your legal representatives in these matters.

Fee Schedule: You or your attorney may request copies of your photos/cd for a reproduction fee of $250.00. A copy of your medical records will be gladly provided to you or your attorney at your request for legal or medical purposes for a reproduction fee of $100.

Form Completion: Dr. Jacobsen and his staff will not complete work-related or disability forms until you have become our valued patient, have had surgery, are kind and gracious to our staff AND fill out ALL the boxes on the form that you can. Then Dr Jacobsen will fill in the medically related information and sign it for you. We will not fill out entirely blank forms. You must do your best to fill out what you can ahead of time.

Please sign below to indicate your understanding these limitations of Dr. Jacobsen's services.

______________________________ ______________

Your Signature Date

CONSENT TO TAKE PHOTOGRAPHS

I hereby authorize William M. Jacobsen, M.D. and or his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs and/or videos. These photographs are important for my patient care and necessary for any procedure, treatment or surgery performed by Dr. Jacobsen. I understand Dr. Jacobsen will protect my privacy and keep these photographs private and secure as a part of my medical record. I understand Dr. Jacobsen will not share my photographs or use my photographs for any other purpose unless a separate agreement for my permission is granted and signed.

I agree that I will not take any photos, videos, or make any recordings of Dr. Jacobsen or his office without receiving his prior verbal permission.

______________________________ ______________

Your Signature Date

MALPRACTICE EXPERT AGREEMENT

Dr. Jacobsen takes great pride in our reputation for providing the highest levels of quality surgical care to our patients. However, we realize there may be times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels Dr. Jacobsen has been negligent in some way. We respect every patient's right to do so.
While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country. These claims are driving up insurance rates and health care costs. These frivolous actions are impacting court decisions for the patients who truly deserve compensation. These frivolous actions are making access to care for some patients in some states impossible. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

We commit to using only American Board of Medical Specialists (ABMS) board certified expert medical witnesses who are plastic surgeons actively practicing in the State of Arizona in any legal situation, who follow the code of ethics of our national specialty societies, The American Society of Plastic Surgeons and The American Society of Aesthetic Plastic Surgery.

We are asking you to employ only ABMS board certified physician expert plastic surgery medical witnesses who are plastic surgeons actively practicing in the State of Arizona if you are dissatisfied with your medical care and decide to pursue legal action.

We believe you will never have to consider this again. But if you do, we will honor this commitment to you as it is in both of our mutual best interests.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I agree to use ABMS board certified expert medical witnesses who are plastic surgeons actively practicing in the State of Arizona. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty societies, the American Society of Plastic Surgeons and the American Society of Aesthetic Plastic Surgery for expert witnesses.

In further consideration for this, I, Dr. William M. Jacobsen, agree to the same.

______________________________ ______________

William M. Jacobsen, M.D. Date

______________________________ ______________

Your Signature Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

**I AUTHORIZE ALL HEALTH CARE PROVIDERS
& HOSPITALS/INSTITUTIONS TO
RELEASE MY MEDICAL RECORDS TO:**

FAX: 602.279.1701
OR
SECURE EMAIL: INFO@DRJSOFFICE.COM

WILLIAM M. JACOBSEN, M.D.
COSMETIC & RESTORATIVE SURGERY
2400 E ARIZONA BILTMORE CIRCLE, SUITE 2450
PHOENIX, AZ 85016
PHONE: 602-212-0100

COMPLETE MEDICAL RECORDS INCLUDING ALL INFORMATION FROM LIST BELOW:

**ALL HOSPITAL AND/OR INSTITUTION RECORDS
TRANSCRIBED HOSPITAL/INSTITUTION RECORDS
(INCLUDES OP NOTES, HISTORY/PHYSICAL EXAMS, CONSULTATIONS, & DISCHARGE SUMMARIES)**

**LABORATORY REPORTS
PATHOLOGY REPORTS
DIAGNOSTIC IMAGING REPORTS
EKG/CARDIAC REPORTS
PHYSICAL/OCCUPATIONAL THERAPY REPORTS
PHYSICIAN OFFICE/CLINICAL RECORDS
IMPLANT INFORMATION (INCLUDING OPERATIVE REPORT)
PHOTOGRAPHS
HIV/AIDS/HEPATITIS RECORDS**

BY SIGNING BELOW, I AUTHORIZE THE RELEASE OF THE ABOVE RECORDS, IF SUCH EXIST:

____________________________________ ____________________
YOUR SIGNATURE **DATE**

THIS DOCUMENT MUST BE SIGNED BY THE PATIENT OR PERSON AUTHORIZED BY LAW.

William M. Jacobsen, MD, FACS
Cosmetic & Restorative Surgery

PATIENT PRIVACY & COMMUNICATION PRACTICES

We want to make our communication with you *Fast and Easy* but for your safety Dr. Jacobsen has important *Privacy & Communication Practices* to protect you!

You have requested that Dr. Jacobsen and his staff communicate with you by e-mail and voicemail. While we will use every possible reasonable means to protect the security and confidentiality of e-mails and voicemails sent and received, we cannot guarantee the security and confidentiality of all e-mail and voicemail communications.

By signing below, I acknowledge that I have read and accept following Patient Privacy & E-Mail Communication Practices and I am aware of the risks of using e-mail and voicemail and agree to communicate with Dr. Jacobsen and his office in this way.

______________________________ ______________

Your Signature Date

Dr Jacobsen wants you to be aware of the Risks of Using E-Mail

Transmitting your private patient information by Unencrypted e-mail has a number of risks that you should consider. These risks include, but are not limited to, the following:

- E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and received by many intended and unintended recipients.
- E-mail senders can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Many employers and online service providers have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.
- E-mail can be lost in transmission.
- E-mails can be posted on the internet or other publicly available networks.

E-MAIL COMMUNICATIONS

- IF OTHERS ARE INVOLVED IN YOUR HEALTHCARE, SUCH AS GUARDIANS OR HEALTH CARE AGENTS, YOUR AUTHORIZATION FOR E-MAIL COMMUNICATIONS EXTENDS TO THEM, UNLESS YOU TELL US OTHERWISE IN WRITING.
- YOU UNDERSTAND AND AGREE THAT WE CANNOT GUARANTEE THE SECURITY, PRIVACY OR CONFIDENTIALITY OF E-MAIL COMMUNICATIONS AND WE WILL NOT BE LIABLE FOR ANY IMPROPER DISCLOSURE OF CONFIDENTIAL INFORMATION, INCLUDING YOUR PATIENT INFORMATION, WHICH IS NOT CAUSED BY OUR INTENTIONAL MISCONDUCT.
- YOU UNDERSTAND AND AGREE THAT ALL E-MAILS BETWEEN US MAY BE PRINTED OR DOWNLOADED AND PLACED IN YOUR MEDICAL RECORD AND ANY PERSON AUTHORIZED TO ACCESS YOUR MEDICAL RECORD WILL HAVE ACCESS TO SUCH E-MAILS. YOU ALSO UNDERSTAND AND AGREE THAT WE MAY FORWARD YOUR E-MAILS TO STAFF AND AGENTS AND HEALTH CARE PROVIDERS AS NECESSARY FOR DIAGNOSIS, TREATMENT, REIMBURSEMENT AND OTHER TREATMENT, PAYMENT OR OPERATIONAL PURPOSES.
- E-MAIL IS PROVIDED AS A CONVENIENCE, NOT AS A SUBSTITUTE FOR PERSONAL TREATMENT OR OTHER MEDICAL CARE. ALTHOUGH WE WILL ENDEAVOR TO READ AND RESPOND PROMPTLY TO AN E-MAIL FROM YOU, WE CANNOT GUARANTEE THAT E-MAILS WILL BE READ AND RESPONDED TO WITHIN ANY PARTICULAR PERIOD OF TIME. IF YOUR E-MAIL REQUIRES OR INVITES A RESPONSE FROM US AND YOU HAVE NOT RECEIVED A RESPONSE WITHIN A REASONABLE TIME PERIOD (PLEASE ALLOW FOR AT LEAST 72 HOURS), IT IS YOUR RESPONSIBILITY TO FOLLOW UP TO DETERMINE WHETHER THE INTENDED RECIPIENT RECEIVED THE E-MAIL AND WHEN THE RECIPIENT WILL RESPOND. SIMILARLY, IT IS YOUR RESPONSIBILITY TO FOLLOW UP AND/OR SCHEDULE AN APPOINTMENT, IF WARRANTED.
- YOU MAY WITHDRAW YOUR REQUEST ONLY BY WRITTEN NOTICE TO US.
- YOU ARE RESPONSIBLE FOR PROTECTING YOUR PASSWORD OR OTHER MEANS OF ACCESS TO E-MAIL. YOU ARE ALSO RESPONSIBLE FOR KNOWING WHO CAN ACCESS YOUR E-MAIL ACCOUNT, SUCH AS A SPOUSE OR A FRIEND, AND SHOULD CHOOSE YOUR E-MAIL ACCOUNT ACCORDINGLY. YOU AGREE THAT WE ARE NOT LIABLE FOR BREACHES OF CONFIDENTIALITY CAUSED BY YOU OR ANY THIRD PARTY.
- YOU AGREE TO WAIVE AND RELEASE US AND OUR DIRECTORS, OFFICERS, MEMBERS, MANAGERS, EMPLOYEES, AGENTS, AND REPRESENTATIVES FROM AND AGAINST ANY AND ALL CLAIMS, LIABILITY, DAMAGES, COSTS AND FEES RELATING TO US E-MAILING YOU YOUR INFORMATION, INCLUDING UNAUTHORIZED ACCESS OR OTHER ISSUES THAT MAY ARISE. IN ADDITION, YOU AGREE TO BE BOUND TO THESE GUIDELINES, AS WELL AS ANY OTHER REQUIREMENTS OR GUIDELINES WE MAY PUBLISH RELATING TO E-MAIL COMMUNICATIONS.
- YOU AGREE TO LIMIT OR AVOID USING YOUR EMPLOYER'S COMPUTER OR OTHER COMPUTERS THAT ARE NOT UNDER YOUR CONTROL, SUCH AS THOSE PROVIDED AT INTERNET CAFÉS OR LIBRARIES.
- YOU AGREE TO PROMPTLY INFORM US IN WRITING OF CHANGES IN YOUR E-MAIL ADDRESS. WE ARE NOT RESPONSIBLE FOR E-MAILS TO A PRIOR ADDRESS IF WE HAVE NOT BEEN ADVISED OF THE CHANGE IN WRITING.
- YOU AGREE TO PUT YOUR NAME IN THE BODY OF AN E-MAIL TO US SO WE KNOW WHO IS SENDING IT.
- YOU AGREE TO INCLUDE THE CATEGORY OF THE COMMUNICATION IN THE E- SUBJECT LINE OF AN EMAIL TO US FOR ROUTING PURPOSES (SUCH AS "BILLING QUESTION", "PRESCRIPTION INFORMATION", "MEDICAL ADVICE").
- YOU AGREE TO REVIEW AN E-MAIL TO US TO MAKE SURE IT IS CLEAR AND THAT ALL RELEVANT INFORMATION IS PROVIDED BEFORE SENDING IT.
- YOU AGREE TO MAKE SURE THAT OUR E-MAIL ADDRESS IS CORRECT BEFORE SENDING AN E-MAIL TO US.
- YOU AGREE TO SEND US A REPLY MESSAGE OR DELIVERY RECEIPT WHEN WE SEND YOU AN E-MAIL SO WE KNOW YOU HAVE RECEIVED IT.
- YOU AGREE TO TAKE PRECAUTIONS TO PRESERVE THE CONFIDENTIALITY OF OUT E-MAILS, SUCH AS USING SCREEN SAVERS AND SAFEGUARDING YOUR COMPUTER PASSWORD.
- YOU AGREE TO ABIDE BY ALL OF THE ABOVE DURING YOUR EMAIL COMMUNICATIONS WITH US.

RECOMMENDATIONS

- IN ORDER TO HELP PROTECT YOUR COMPUTER AGAINST MALICIOUS SOFTWARE AND SAFEGUARD YOUR INFORMATION, SOFTWARE AND SYSTEM COMMUNICATIONS WE RECOMMEND YOU INSTALL AND REGULARLY UPDATE PROTECTIVE SOFTWARE, SUCH AS FIREWALL, ANTI-VIRUS AND ANTI-SPYWARE PROGRAMS.
- IN ORDER TO HELP REDUCE THE THREAT OF PEOPLE INAPPROPRIATELY INTERCEPTING AND READING YOUR E-MAILS, WE RECOMMEND YOU USE SOFTWARE TO ENCRYPT YOUR E-MAILS THAT CONTAIN INFORMATION YOU DETERMINE TO BE CONFIDENTIAL

PATIENT PRIVACY

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.

William M. Jacobsen, MD, P.C. is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office, a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Our practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment**: We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment**: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations**: We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. **Appointment Reminders**: We may use and disclose your information to remind you of appointments. We may also mail you a reminder for follow-up visits.
5. **Treatment Options**: We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. **Business Associates**: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- For product recalls
- To report adverse reactions to medications
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.

- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes, such as military service or for national security.
- In the event of an emergency or for disaster relief.
- For a hospital directory
- To provide mental health care services with your prior written permission.
- To market our services and sell your information with your prior written permission.
- To raise funds, but after the first contact you can request that we not contact you again.
- In any other instance required by law.

If you are not able to tell us your preference, for example if you are unconscious, practice may go ahead and share your information if we believe it is in your best interest. Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our office in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **RESTRICTIONS ON USE AND DISCLOSURE**: YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION. THIS INCLUDES REQUESTS TO RESTRICT DISCLOSURE OF YOUR HEALTH INFORMATION TO ONLY CERTAIN INDIVIDUALS, OR ENTITIES, INVOLVED IN YOUR CARE SUCH AS FAMILY MEMBERS AND INSURANCE COMPANIES. WE ARE NOT REQUIRED TO AGREE WITH YOUR REQUEST. IF WE AGREE, WE ARE BOUND TO THE AGREEMENT UNLESS DISCLOSURE IS OTHERWISE REQUIRED OR AUTHORIZED BY LAW. IF YOU PAY FOR A SERVICE OR HEALTH CARE ITEM OUT-OF-POCKET IN FULL, YOU CAN ASK US NOT TO SHARE THAT INFORMATION FOR THE PURPOSE OF PAYMENT OR OUR OPERATIONS WITH YOUR HEALTH INSURER. WE WILL SAY "YES" UNLESS A LAW REQUIRES US TO SHARE THAT INFORMATION.
2. **CONFIDENTIAL COMMUNICATIONS**: YOU HAVE THE RIGHT TO REQUEST THAT WE COMMUNICATE WITH YOU OR SOMEONE YOU CHOOSE TO ACT FOR YOU IN A PARTICULAR MANNER OR AT A CERTAIN LOCATION. FOR EXAMPLE, YOU MAY REQUEST THAT WE ONLY CONTACT YOU AT HOME. WE WILL ACCOMMODATE REASONABLE REQUESTS. IF YOU HAVE GIVEN SOMEONE MEDICAL POWER OF ATTORNEY OR IF SOMEONE IS YOUR LEGAL GUARDIAN, THAT PERSON CAN EXERCISE YOUR RIGHTS AND MAKE CHOICES ABOUT YOUR HEALTH INFORMATION. WE WILL MAKE SURE THE PERSON HAS THIS AUTHORITY AND CAN ACT FOR YOU BEFORE WE TAKE ANY ACTION.
3. **ACCESS**: YOU HAVE THE RIGHT TO INSPECT OR REQUEST A COPY OF RECORDS USED TO MAKE DECISIONS ABOUT YOUR HEALTH CARE, INCLUDING YOUR MEDICAL CHART AND BILLING RECORDS. THIS OFFICE WILL SCHEDULE APPOINTMENTS FOR RECORD INSPECTION. WE MAY CHARGE A FEE FOR PROVIDING YOU COPIES OF YOUR RECORDS. UNDER SPECIAL CIRCUMSTANCES, WE MAY DENY YOUR REQUEST TO INSPECT AND/OR COPY YOUR RECORDS. YOU MAY REQUEST A REVIEW OF THIS DENIAL. YOU MAY ALSO REQUEST AN ELECTRONIC COPY OF YOUR RECORDS BE PROVIDED. THIS ELECTRONIC COPY MAY BE SENT USING E-MAIL TO YOUR SPECIFIED ADDRESS, CD FOR FLASH DRIVE. PLEASE NOTE THAT E-MAIL COMMUNICATIONS ARE NOT A SECURE METHOD FOR TRANSPORT.
4. **RECORD AMENDMENT**: YOU HAVE THE RIGHT TO REQUEST AMENDMENTS TO YOUR HEALTH RECORDS CREATED BY AND FOR THIS PRACTICE IF YOU FEEL THEY ARE INCORRECT OR INCOMPLETE. WE MAY ACCEPT OR DENY YOUR REQUEST. IF WE DENY YOUR REQUEST, YOU HAVE THE RIGHT TO PROVIDE A STATEMENT OF DISAGREEMENT.
5. **ACCOUNTING OF DISCLOSURES**: YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES. THIS MEANS YOU MAY REQUEST A LIST OF CERTAIN DISCLOSURES PRACTICE HAS MADE OF YOUR RECORDS. UPON YOUR REQUEST, WE WILL PROVIDE THIS INFORMATION TO YOU ONE TIME FREE DURING EACH TWELVE (12) MONTH PERIOD. THERE MAY BE A FEE FOR ADDITIONAL COPIES.
6. **COPY OF NOTICE**: YOU HAVE THE RIGHT TO REQUEST THAT WE PROVIDE YOU WITH A PAPER COPY OF THIS NOTICE OF PRIVACY PRACTICES.

WHEN FEDERAL AND STATE PRIVACY LAWS DIFFER, AND STATE LAW IS MORE PROTECTIVE OF YOUR INFORMATION OR PROVIDES YOU WITH GREATER ACCESS TO YOUR INFORMATION, STATE LAW MAY OVERRIDE FEDERAL LAW.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR PRACTICE'S PRIVACY OFFICER AT (602) 212-0100. IF YOU FEEL YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU HAVE THE RIGHT TO FILE A WRITTEN COMPLAINT WITH OUR OFFICE. YOU MAY ALSO FILE A COMPLAINT WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE FOR CIVIL RIGHTS BY SENDING A LETTER TO 200 INDEPENDENCE AVENUE, S.W., WASHINGTON, D.C 20201, CALLING 1-877-696-6775, OR VISITING WWW.HHS.GOV/OCR/PRIVACY/HIPAA/COMPLAINTS/

THERE WILL BE NO RETALIATION FOR FILING A COMPLAINT.

FOR MORE INFORMATION SEE WWW.HHS.GOV/OCR/PRIVACY/HIPAA/UNDERSTANDING/CONSUMERS/NOTICEPP.HTML.