Patient Information and Acknowledgement Questionnaire

Patient Information – Please Print

First Name:____________________________ Last Name:______________________________ Middle Initial:_________

Date of Birth:_____________ Sex:________ Race:____________ Are you of Hispanic/Latino Decent?(Yes/No):______

Permanent Address: ____City: ____________ State: _______ Zip: ______
Temporary Address: ____City: ____________ State: _______ Zip: ______

Contact Information – *Check the box next to the best contact number*

☐ Home Phone: (______)____________ ☐ Work Phone: (____)_____________ ☐ Cell Phone: (____)_____________
Email Address: ____________________________________ Please contact me by: ☐ Phone ☐ Email ☐ Mail
Emergency Contact Name: ___________________________Relationship: ___________Phone: (___)________________

Preferred Pharmacy

Pharmacy Name: ____ Phone Number (____)_____________

Approximate Location (cross streets, city, etc.):____

Provider Information

Referring Physician: ________________________________ Primary Care Physician:______________________________

Responsible Party Insurance / Billing Information

Primary/Secondary Insurance Company: ____

Responsible Party: ______________________ DOB:___________________ Relationship to Patient:________________

Address (if different than above): ____________________________________ Phone Number: (______)____________

Reproductive History

Is there a possibility you may be pregnant? ☐ Yes ☐ No Date of LMP: ________________________________

Medical History - Please List ALL Current Medical Problems and the Physician Treating Them:

____ ____
____ ____
____ ____
____ ____

Surgical History - Please List ALL Past Surgeries & What Year Performed:

____ ____
____ ____
____ ____

Allergies – Please List all Allergies and Reaction:

____ ____
____ ____
____ ____

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First Name:___________________ **Last Name:**__________________ **Middle Initial:**____ **Date of Birth:**_____________

Medications- Please List ALL Medications, Dose, Frequency and Reason:

____ ____
____ ____
____ ____
____ ____

Family Medical History:

Mother: __Alive __Deceased

____
____

Father: __Alive __Deceased

____
____

Sibling(s): __Alive __Deceased

____
____

Other (please list): ___________________________

____
____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation(s): *Please be specific about any occupations where you may have been exposed to hazardous materials*

____
____

Tobacco Usage: ☐ Currently, Every Day ☐ Currently, Some Days ☐ Former ☐ Never

Tobacco Amount Used/Day: ______________ **Age Started:** ___________ **Age Stopped:**_______

Alcohol Consumption: ☐ Currently, Every Day ☐ Currently, Some Days ☐ Former ☐ Never

Alcohol Amount Used: __________________, **per** ☐ Day ☐ Week ☐ Month

Type of Alcohol: ☐ Beer ☐ Wine ☐ Liquor ☐ Multiple

Illicit Drug Use: ☐ Currently, Every Day ☐ Currently, Some Days ☐ Former ☐ Never

Medicinal Marijuana: ☐ Currently, Every Day ☐ Currently, Some Days ☐ Former ☐ Never

Patient Policy Acknowledgement

Acknowledgement – Receipt of Patient Rights and Responsibilities

By my signature on page 3, I acknowledge receipt of the Patient Rights and Responsibilities, and have been given the opportunity to read it. I understand that this information is available to me upon my request.

Acknowledgement- Notice of Privacy Practices Receipt

By my signature on page 3, I acknowledge receipt of CiC's Notice of Privacy Practices (HIPAA) and have been given the opportunity to read it. I understand that this information is available to me upon my request.

Appointment Policy

Please call us at (480) 374-7354 by 2:00 pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 pm on Friday. If prior notification is not given, you will be charged $50 for the missed appointment.

First Name:___________________ Last Name:__________________ Middle Initial:____ Date of Birth:_____________

Payment Policy

CIC is committed to providing you with the highest quality care. Please review our Payment Policy, should you have questions we will discuss prior to your exam. **Insurance:** We participate with plans, most insurance plans including Medicare. If you are not insured by a plan we are contracted with, payment in full is due at the time of your exam is performed. If you are insured by a plan we are contracted with, but do not have your insurance information, payment in full is due at the time your exam is performed. Once we obtain your insurance information, we will bill the insurance company and refund your payment after the claim has been paid in full.

Co-Payments, Deductible, & Co-Insurance: All co-payments, deductibles and co-insurance must be paid at the time your exams are performed per your contract with your insurance company.

Non-Covered Services: In some instances, the services you receive may not be covered or not considered medically necessary by Medicare or other insurance companies. In these instances, you will be required to pay for these services in full at the time of your exam.

Proof of Insurance: We may require that we obtain a copy of your driver's license and valid insurance card to provide proof of insurance. If we are not provided with the correct information, you will be held responsible for the balance of the claim.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get the claim paid.

Coverage Changes: If your insurance changes, notify us immediately to avoid problems with your claim being paid. By my signature below, I acknowledge CIC's Payment Policy. I hereby assign all insurance benefits to CIC for services performed

Non-insured patients: I agree that I am responsible for payment at the time of service, unless prior arrangements have been made.

Referral & Insurance Card Responsibility: I understand that during the check in process, if I do not have my referral and/or insurance card, I will be responsible for any payment rendered at the time of service.

Deductible/Coinsurance: I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible has been met, my coinsurance amount may be collected at time of service.

Non-covered procedures: I agree to pay for all non-covered services (preventative or routine) not covered by my insurance.

Collections: Once an account is placed in collection status, all future services must be paid in full at the time of service. I understand that there will be a $25.00 fee for any returned checks.

Acknowledgement – Medical Record Request

By my signature below, I hereby authorize CIC to **obtain** and/or **disclose** my medical records for medical treatment purposes only to my physician(s), clinic, hospital, or to my insurance company without further written permission for continuation of care. Medical records request(s) up to 10 pages will be provided at no charge to the patient, request(s) larger than 10 pages may incur a fee.

General Consent and Right to Refuse Treatment

General Consent to Treatment: By my signature below, I (or my authorized representative on my behalf) authorize CIC and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reason(s) for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment or medication recommended or deemed medically necessary as prescribed by my referring physician. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of my evaluation and/or treatment. Unless otherwise revoked, this authorization will expire in 1 year from date of signature.

Advanced Directives

You have the right to information on CIC's policy regarding Advanced Directives. Advanced Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR- Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. IMPORTANT: Under Arizona law a Prehospital Medical Directive or DNR must be on letter sized paper or wallet sized paper of an orange background to be valid.

Patient or Authorized Representative

Signature: ____ Date: ________________

Authorization to Communicate Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

PATIENT NAME: ____ **DATE OF BIRTH**:______________

Section 1: In the event that I am unavailable**,** I hereby authorize CICC to communicate my protected health information, including information regarding my billing, condition, treatment and diagnosis to the following individual(s) or entity:

Name:___________________________ **Relationship:**____________________ **Phone Number:**________________________

Name:___________________________ **Relationship:**____________________ **Phone Number:**_________________________

***Note:** *If your records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, mental health information, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing the disclosure of this information.*

Section 2: Text Message Communication – Duty to Warn

Comprehensive Integrated Care (CiC) is committed to protecting your privacy. We offer several secure and preferred forms of communication with our staff such as a telephone call and/or encrypted email. While text messaging is very convenient, it is not a secure method of communication, and places any information transmitted in this format at risk of being intercepted by someone who has not been given permission. Text messaging is not Comprehensive Integrated Care's preferred method of communication. It is not expected that staff provide their personal cell phone number to our patients. If you request a text message from the staff, it is important that you understand the risk to your personal protected health information.

- I understand that text messages are not a secure form of communication because it lacks encryption.
- I understand that CiC will not be able to know with any certainty whether the message is received by me which could compromise the security of my protected health information.
- I understand that text messages are transmitted over a public network onto a personal telephone and as such are not secure.
- I understand that my telecommunication vendor/wireless carrier may store text messages which may be viewed without my permission.
- I agree to advise CiC if my mobile number changes or if this is no longer in my possession.

Consent (Check One):

☐ I have reviewed and understand the information above, and I CONSENT to text message communication. I understand that CiC personnel are not required to release their personal cell phone number.

☐ I have reviewed and understand the information above, and I DECLINE text message communication.

Section 3: **Section 3:** I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from date of signature.

____ _______________________________

Signature of Individual (Person whom the Information Relates) Date of Signature

– OR –

____ _______________________________

Signature of Patient Representative Date of Signature

____ _______________________________

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Date: _______________

Name: ________________________________ DOB: _______________

REVIEW OF SYSTEMS

Are you experiencing any of these symptoms TODAY?

Legs – Vascular:

☐Swelling ☐Skin Discoloration ☐Varicose Veins
☐Leg Cramps ☐Heaviness ☐Ulcers or Sores
☐Ankle Skin thickening/dryness ☐Rupture of Vein ☐Pain
☐Restless Leg ☐Itching ☐Fatigue

Constitutional:

☐Currently Pregnant ☐Fever ☐Weight Loss
☐Night Sweats ☐Chills ☐Weight Gain

Cardiovascular:

☐Chest Pain ☐Syncope

Respiratory:

☐Shortness of Breath

Eyes:

☐Changes in Vision

Gastrointestinal:

☐Nausea/Vomiting ☐Jaundice ☐Blood in Stools

Genitourinary:

☐Painful Urination ☐Nocturia

Genitourinary - Female Only:

☐Pelvic Varicose Veins ☐Pelvic Pain ☐Back Pain
☐Heavy Bleeding ☐Painful Intercourse ☐Cramping

Integumentary:

☐Rash ☐Itching

Neurological:

☐Tingling or Numbness ☐Dizziness ☐Seizures

Musculoskeletal:

☐Muscular Weakness

Endocrine:

☐Cold Tolerance ☐Heat Intolerance

Psychiatric:

☐Anxiety ☐Depression

Heme-Lymph:

☐Easy Bleeding ☐Lymph Node Enlargement ☐Lymph Node Tenderness

Do you have open sores or wounds on your legs or feet? ☐No ☐Yes - How long? ______________

Other: ____

None: ☐

Name: ______________________________ Date: ______________

DOB: ______________

PAD is a condition that raises the risk for heart attack and stroke. It affects 8 to 12 million people in the United States.*

Are you one of them?

Analyze your risk for PAD

1. Do your legs and/or feet ever feel numb?	◯ YES	◯ NO
2. Do you ever have a burning pain in your legs and/or feet?	◯ YES	◯ NO
3. Do your legs hurt, get tired, or cramp when you walk?	◯ YES	◯ NO
4. Do your feet or legs cramp in bed, does standing relieve it?	◯ YES	◯ NO
5. Are your feet always cold in bed at night?	◯ YES	◯ NO
6. Does it hurt when the sheets touch your skin?	◯ YES	◯ NO
7. Do you have sores on your legs or feet that won't heal?	◯ YES	◯ NO
8. Do you think you have neuropathy?	◯ YES	◯ NO
9. Are your symptoms worse at night?	◯ YES	◯ NO
10. Do your feet look blue or purple?	◯ YES	◯ NO

If you've answered "yes" to 2 or more of these questions, you may have PAD. Be sure to talk to your doctor about these symptoms.

Early recognition leads to early treatment which may lead to a better outcome.

*"Stay in Circulation: Campaign Materials: Facts about Peripheral Arterial Disease (P.A.D.)." *National Heart Lung and Blood Institute*, U.S. Department of Health and Human Services, www.nhlbi.nih.gov/health/educational/pad/materials/pad_extfctsht_general.html.

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Patient Rights and Responsibilities

Comprehensive Integrated Care (CiC) is committed to provide our patients with the most advanced medical care available. As a patient of CiC, you have certain rights and responsibilities. Please review carefully, it is important that you understand them.

You have the Right:

- Be treated with dignity, respect and consideration.
- Receive assistance in a prompt, courteous and responsible manner.
- Not to be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse or sexual assault, restraint or seclusion, retaliation for submitting a complaint to any entity, or misappropriation of personal or private property by CiC's personnel member, employee, volunteer, or student.
- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
- Receive privacy in treatment and care for personal needs.
- Confidential handling of all communications and medical information maintained at CiC, as provided by law and medical ethics. Your written permission will always be required for CiC's release of Private Health Information (PHI) except when:
    - Health professionals providing for your care request clinical information.
    - CiC is legally obligated to release PHI.
    - CiC prepares and releases information in the form of statistical summaries that do not identify individuals.
    - Information is necessary to support or facilitate claims payment, utilization management or quality management.
- Review, upon written request, the patient's own medical records.
- Be informed by your health care provider of services you will receive in terms you understand.
- Be informed by CiC healthcare professionals about any treatment/services you may receive. Your health care professional should request your consent for all treatment, unless there is an emergency and your life, and your health are in serious danger.
- Participate or have the patient's representative participate in the development of, or decisions concerning, treatment.
- Receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.
- Refuse treatment to the extent allowed by law and be advised of possible consequences of your decision by CiC health care professionals. We encourage you to discuss your objection with your referring physician before scheduling with CiC. They will advise and discuss alternative treatment plans with you, but you will have the final decision regarding your healthcare.
- Participate or refuse to participate in research or experimental treatment.
- Receive a referral to another health care institution if the center is not authorized or able to provide physical health services or behavioral health services needed by the patient. Express a complaint about CiC and/or the quality of care you have received and to receive a response in a timely manner.
- Initiate the grievance procedure if you are not satisfied with CiC's decision regarding your complaint.
- Be provided with information pertaining to your financial responsibility for all services rendered.

You have the Responsibility to:

- Provide honest and complete information to those providing your care.
- Keep scheduled appointments or notify CiC if you will be delayed as soon as reasonably possible; or, if unable to keep scheduled appointments, notify the office 48 hours in advance.
- Relay any current medication(s) you are taking or any medical allergies to a CiC healthcare provider.
- Ask questions when you do not understand information or instructions. Make it known whether or not you understand the care and diagnostic tests to be performed and take an active role in your treatment by being informed, prepared, and adhere to any pre and post procedure instructions.
- Comply with the rules of our facility, including our visitor and smoke-free environment policies.
- Express your opinions, concerns or complaints in a constructive manner to the appropriate people at our facility as they arise.
- Learn how to access information pertaining to your health care coverage.
- Show respect and consideration for the rights of fellow patients, the staff and our property.
- Behave in a manner that is not disruptive to the delivery of healthcare or to themselves or others.
- Inform us about any living will, medical power of attorney, or other directive that may affect your care.
- Verify with your insurance company whether CiC participates with their insurance plan and if you have deductibles and/or co-pays.
- Present your insurance card and proper identification prior to receiving services.
- Pay all charges, if any, for appointments and non-covered services at the time service is rendered.
- Accept personal financial responsibility for any charges not covered by your insurance.

An Administrator Shall Ensure That:

- A patient or the patient's representative either consents to or refuses treatment, except in an emergency.
- A patient or the patient's representative may refuse or withdraw consent before treatment is initiated.
- A patient or patient's representative is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure, except in emergencies.
- A patient or patient's representative is informed of the center's policy on health care directives and patient complaint process.
- A patient has consented to a photograph before it is taken, except that a patient may be photographed when admitted to the facility for identification on and administrative purposes.
- A patient provides written consent to release information in the patient's medical record or financial records, except as otherwise permitted by law.

If at any time you have question or concerns regarding your Rights and Responsibilities, please ask to speak to the local center manager. If you feel your rights have been violated, you may also contact our Compliance Hotline at 1-844-424-2236.

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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.

Comprehensive Integrated Care (CIC) is required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain.

Uses and Disclosures of Your Protected Health Information:

Treatment: We are permitted to use your medical information as necessary to provide you with medical treatment and services. We may disclose information about you to physicians, nurses, technicians, medical students, or other workforce members who are involved in taking care of you at or through CIC. To assist with your care outside CIC, we may disclose your information to other health-care providers.

Payment: We are permitted to use and disclose your medical information to get paid for the services you received. For example, we may disclose information about your exam or procedure to your insurance company so that your insurance company will pay us. We also may tell your insurance company about treatment you are going to receive in order to obtain approval or to determine whether your insurance will cover the treatment. We may disclose your health information to other providers who are involved in your care for their payment purposes. For example, we may release information to emergency responders to allow them to obtain payment or reimbursement for services provided to you.

Health Care Operations: We are permitted to use your medical information for our business operations. Business operations include training of medical personnel, peer review, and quality improvement. We may disclose your information to another health care provider or health plan if they have a relationship with you and need the information for their own business operations. For example, our quality management department may use your health information to assess the quality of care you received and to ensure that our system continues providing the quality of care you and other patients deserve.

Appointment Reminders and Treatment Alternatives, and Health-related Benefits and Services: We may use and disclose your medical information to contact you to remind you that you have an appointment scheduled, to tell you about or recommend possible treatment options or alternatives that may be of interest to you, or to tell you about a product or service that may be of interest to you.

Family Members and Others Involved in Your Care: CIC may disclose your medical information to your family members or friends who are involved in your care, or to someone who helps to pay for your care. CIC may also disclose your medical information to disaster relief organizations to help locate individuals during a disaster, or to notify, or assist in the notification, of a family member, a personal representative or a person responsible for your care of your location, general condition or death. If you do not want CIC to disclose your medical information to family members or others in these circumstances, please notify CIC staff.

Health Oversight Activities: We may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities include government audits, investigations, and inspections. We may also provide your medical information to a government agency that oversees licensing of health care professionals, such as the Arizona Medical Board.

Incidental Disclosures: Incidental disclosures of your health information may occur as a by-product of permitted use and disclosures of your health information. These incidental disclosures are permitted if we have applied reasonable safeguards to protect the confidentiality of your health information.

Inmates: If you are an inmate of a correctional facility or are under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary to provide you with health care or to protect your health and safety or the health and safety of others, including the correctional institution.

Law Enforcement: We may disclose your health information to law enforcement officials as required by law or as directed by court order, warrant, criminal subpoena, or other lawful process and in other limited circumstances for purposes of identifying or locating suspects, fugitives, material witnesses, missing persons, or crime victims.

Legal Proceedings: We may disclose health information about you in response to a court or administrative order. We also may disclose medical information about you in response to a civil subpoena, discovery request, or other lawful process by someone involved in legal proceedings. In many cases you will receive advance notice about this disclosure so that you will have a chance to object to sharing your medical information.

Communicable Diseases: If authorized by law, we may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request or other lawful process.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities. We also may release health information about foreign military personnel to the appropriate foreign military authority.

National Security, Intelligence, Activities, Protection Services for the President, and Others: We may disclose your medical information to authorized federal officials for lawful intelligence, counterintelligence, or other national security activities authorized by law; for protection of the U.S. President, other authorized persons or foreign heads of state; or for special authorized investigations.

Public Health Activities: We may disclose your medical information for public health activities as authorized by law. These activities typically include reports to such agencies as the Department of Health.

Human Services or the Food and Drug Administration: The disclosures are usually made for the purpose of preventing or controlling disease, injury, or disability. Examples include reporting of disease, injury, and vital events such as births and deaths, reporting of child and elder abuse, and reporting of reactions to medications and problems with products.

Research: Under certain circumstances, we may use and disclose your medical information for research purposes. All research projects are subject to a special approval process by an Institutional Review Board. This review process governs patient safety and welfare and the privacy of your medical information. Under special circumstances involving research, a Privacy Board has been established to monitor and protect your privacy rights.

Marketing: We may use your medical information to provide you with certain refill reminders, for treatment, case management or care coordination, to direct or recommend alternative treatments, therapies, health care providers, or settings of care, or to describe a health-related product or service provided by CIC. CIC will obtain your authorization prior to using or disclosing your protected health information for purposes of marketing items and services to you and where CIC is paid to make the communication.

Fundraising: CIC may contact you to raise funds for CIC. You have the right to opt out of receiving such communications. To opt out of receiving such communications, send a written request to the CIC Privacy Officer at: 4001 E Baseline Road Suite 107, Gilbert Arizona 85234.

Sale of PHI: CIC may not sell your health information without your written authorization.

Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose your medical information when necessary, to prevent a serious threat to your health and safety or the health and safety of others

Workers' Compensation: We may release your information about you for workers' compensation or similar programs as authorized by law. These programs provide benefits for work-related injuries or illness.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation if you have previously agreed to organ donation.

Information with Additional Protection: Certain types of medical information have additional protection under Arizona law. In some circumstances, CIC will require your consent to disclose information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and mental health treatment.

Psychotherapy Notes: CIC will not use or disclose your psychotherapy notes without your authorization, unless the use is by the person who wrote the notes for purposes of treatment, for training of medical or counseling professionals, or for CIC to defend itself in a legal proceeding brought by you. In addition, any disclosure or use must be to the Department of Health and Human Services; required by law; for the health oversight of the practitioner that wrote the notes; to the coroner or medical examiner; or to avert a serious threat to the health or safety of a person or the public.

Other Uses and Disclosures: Uses and disclosures of your information not described in this notice require your written authorization. If you provide CIC with an authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we cannot take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we provided to you. To revoke your authorization, please write to the Medical Records Department of the appropriate CIC location.

Copy of This Notice: You have the right to receive a paper copy of this notice and any revisions to it upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy: You have the right to inspect and copy the medical information we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or medical information that is subject to a law that prohibits access to the medical information. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer, Comprehensive Integrated Care (CIC), 4001 E Baseline Road Suite 107 Gilbert AZ, 85234. Please identify in your request the location or office at which you received services. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice sites, although we may extent the time an additional 30 days but, must inform you of this delay.

Request Amendment: You have the right to request we amend your medical information. You must make this request in writing to our Privacy Officer. The request must state the reason for the amendment. We may deny your request if it is not in writing or does not state the reason for the amendment. We may also deny your request if the information: was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.

Request Restrictions: You may request CIC restrict or limit the health information it uses or discloses about you for treatment, payment or health care operations. Additionally, you have the right to request our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members or friends. CIC is not required to agree to your request for a restriction, unless you request that we not share your medical information with your health insurer about a service for which you (or someone other than your insurer) has paid in full and the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law.

Accounting of Disclosures: You have the right to request a list of certain disclosures of your medical information. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications: You have the right to request how we communicate with you to preserve your privacy. We may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our Privacy Officer. The request must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint: You have the right to file a complaint if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint. Complaints may be submitted:

1.) In writing to our Privacy Officer at the following address:

    Comprehensive Integrated Care
    Attn: Privacy Officer
    4001 E Baseline Road Suite 107
    Gilbert Arizona 85234

2.) Compliance Hotline 1-844-424-2236 **You have the option of filing the compliant anonymously using the hotline.*
3.) You can file a complaint with the U.S. 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: 1-877-6966775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

Notification if Confidentiality is Breached: We are required to notify affected individuals following a breach of unsecured medical information.

Changes to this Notice: CIC reserves the right to change the terms of this notice and to make the new notice provisions effective for all medical information we maintain. You may receive a copy of any revised notice at the CIC facility after it becomes effective.