Patient Demographic Form

Please PRINT

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other | **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address | **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Physician ❑ Radio ❑ Television ❑ Website ❑ Yellow Pages ❑ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer | **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ❑ Cell ❑ Pager ❑ Fax

AZ INTEGRATIVE
RHEUMATOLOGY

PATIENT INTAKE FORM

Legal Name:

How do you like to be addressed?

Date of Birth:

CONCERNS

Thank you for taking the time to fill out this intake form. We know it's comprehensive, but by gathering this information about your health history and goals helps give your naturopathic doctors a more complete understanding of you. We want to help you reach your optimal health.

Most important concern you would like to address?

Additional concerns?

FAMILY HISTORY

Grandparents:
Ages:
Living or Deceased:
Parents:
Ages:
Living or Deceased:
Siblings:
Ages:
Living or Deceased:

List any significant prior illnesses, diagnoses, or injuries, including date occurred (ie. hypertension, March 2015)

List all surgeries and hospitalizations, including reason and date occurred?

Please list any major accident or illness during childhood not already indicated?

Date of last physical exam?

Date of last blood work?

Medical Imaging

X-ray: Provide date, area of body, and reason?

MRI/CAT Scan: Provide date, area of body, and reason?

Ultrasound: Provide date, area of body, and reason?

Has any blood relatives ever had any of the following?

☐ Cancer	☐ Tuberculosis
☐ Asthma	☐ Mental Illness or suicide
☐ Diabetes	☐ High Blood Pressure
☐ Allergies	☐ Autoimmune Disease
☐ Heart Attack	☐ Heart Disease
☐ Stroke	☐ Osteoporosis
☐ Other	

If YES, check appropriate box and please indicate who below (maternal aunt, paternal grandmother, father, son, sister, etc)

Medications / Supplements

Current Medications and Supplements (please include ALL prescriptions, over-the-counter drugs, vitamins, herbs, etc.). Please include daily dose and reason for taking it.

Allergies

Please indicate allergies?

- ☐ No known or suspected allergies
- ☐ Medication
- ☐ Foods
- ☐ Environmental

Please indicate allergy and describe reaction:

Sleep

How many hours of sleep do you usually get per night?

Do you wake feeling refreshed?

☐ Always ☐ Usually ☐ Rarely ☐ Never

Do you have difficulty sleeping?	☐ Yes	☐ No
Any trouble falling asleep?	☐ Yes	☐ No
Any trouble staying asleep?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you grind your teeth?	☐ Yes	☐ No
Do you have nightmares?	☐ Yes	☐ No
Do you sleepwalk?	☐ Yes	☐ No
Do you wake due to pain?	☐ Yes	☐ No

Do you need a sleep-aid?

☐ Yes, indicate what ☐ No

Alcohol, Tobacco, and Recreational Drug Use

Do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ No

What type of alcohol do you prefer?

☐ Liquor ☐ Wine ☐ Beer ☐ Other

How much do you drink per sitting? Indicate amount consumed per occasion.

SOCIAL HISTORY

What is your current job?

Do you enjoy your job? ☐ Yes ☐ No

What are your hobbies?

Have you done any foreign travel within the last year?

☐ Yes, indicate where ☐ No

Please indicate your average level of energy throughout the day using the scale 1-10 (1 is the lowest and 10 is the highest)

Do you exercise? If YES, indicate type of exercise, how many days per week, and for how long? (i.e. bicycling, 3 days, 60 minutes)

☐ Yes, describe ☐ No

If Yes or in the past, what kind?

☐ Cannabis	☐ Barbiturates/benzodiazepines
☐ Solvents	☐ Psychedelic mushrooms
☐ Heroin	☐ LSD
☐ Opium	☐ Peyote
☐ Ecstacy	☐ Amphetamines
☐ Cocaine	☐ Other

Have you ever been told you have an addiction or been treated for an addiction?

☐ Yes ☐ No

Does the use of alcohol or drugs impair your activities of daily living?

☐ Yes ☐ No

Diet

Do you follow a special diet (ie South Beach, Paleo, Vegan, Blood-type, etc.)?

☐ Yes, indicate type ☐ No

How many ounces of water do you drink each day?

How many meals do you eat a day?

Do you drink energy drinks?

☐ Daily ☐ Weekly ☐ Monthly ☐ No

Please indicate what kind of energy drink and how much:

Do you smoke or chew tobacco ?

☐ Yes ☐ No ☐ In the past

If yes, how many cigarettes or packs per day?

If past, when did you quit smoking, number of years smoking, and packs per day?

Do you use recreational drugs?

☐ Yes ☐ No ☐ In the past

If yes, how often?

☐ Daily ☐ Weekly ☐ Monthly ☐ Other

Do you live alone?

☐ Yes ☐ No

Do you have a support system?

☐ Strong ☐ Moderate ☐ Limited

Major stressors in the last year?

- ☐ Money
- ☐ Job
- ☐ Marriage/relationship
- ☐ Home life
- ☐ Children
- ☐ Loss
- ☐ Other

Do you find your life?

- ☐ Satisfactory
- ☐ Unsatisfactory
- ☐ Boring
- ☐ Too demanding

Do you drink soda, juice or sports drinks?

☐ Daily ☐ Weekly ☐ Monthly ☐ No

Please indicate what kind of soda, juice or sports and how much:

How many 8oz cups of coffee do you drink daily?

Relationship

Relationship status?

☐ Single	☐ Separated
☐ Married	☐ Divorced
☐ Domestic partner	☐ Widowed
☐ In a relationship	☐ Other

Are you satisfied with your significant relationships?

☐ Yes ☐ No

Do you have a history of abuse? Check all that apply.

- ☐ Mental abuse
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse

If yes, by whom and at what age?

How would you define your childhood memories?

- ☐ Mostly happy
- ☐ Normal
- ☐ Mostly painful
- ☐ Denies recollection

Review of Systems:

Please mark any symptoms which you've experienced WITHIN THE LAST MONTH

RATE EACH SYMPTOM 1 to 4 , where 1 = infrequent 2 = somewhat frequent 3 = few days per week 4 = daily

General

- ☐ weight change
- ☐ appetite change
- ☐ fever/chills
- ☐ weakness
- ☐ fatigue
- ☐ night sweats

Eyes

- ☐ dryness
- ☐ watery eyes
- ☐ itching eyes
- ☐ redness of the eye
- ☐ eye strain
- ☐ cataracts
- ☐ styes
- ☐ dark circles around eyes
- ☐ discharge of the eye
- ☐ contacts/glasses
- ☐ problems with vision
- ☐ glaucoma

Date of last eye exam:

Eyes

- ☐ dryness
- ☐ watery eyes
- ☐ itching eyes
- ☐ redness of the eye
- ☐ eye strain
- ☐ cataracts
- ☐ styes
- ☐ dark circles around eyes
- ☐ discharge of the eye
- ☐ contacts/glasses
- ☐ problems with vision
- ☐ glaucoma

Date of last eye exam:

Ears/Nose/Throat

- ☐ ringing
- ☐ change in hearing
- ☐ ear discharge
- ☐ ear pain
- ☐ vertigo
- ☐ Nose bleeds
- ☐ Polyps
- ☐ Problems smelling
- ☐ Postnasal discharge
- ☐ nasal congestion
- ☐ nasal discharge
- ☐ sinusitis
- ☐ sore throat
- ☐ hoarseness
- ☐ gum disease
- ☐ mouth sores
- ☐ Problems swallowing
- ☐ Goiter
- ☐ Diminished neck movement
- ☐ Problems tasting
- ☐ cavities

Urinary Tract

- ☐ incontinence
- ☐ kidney stones
- ☐ blood in urine
- ☐ urgency
- ☐ frequent urination
- ☐ frequent infections
- ☐ pain with urination
- ☐ waking to urinate

Musculoskeletal

- ☐ muscle weakness
- ☐ muscle aches
- ☐ tremors
- ☐ arthritis
- ☐ leg cramps
- ☐ stiffness
- ☐ past injury
- ☐ head injury

Cardiovascular

- ☐ murmurs
- ☐ palpitations
- ☐ heart attack
- ☐ arrhythmias
- ☐ angina
- ☐ TIA/stroke(s)
- ☐ chest pain
- ☐ leg cramps
- ☐ congestive heart failure
- ☐ blue hands/feet
- ☐ rheumatic fever
- ☐ low blood pressure
- ☐ high blood pressure
- ☐ varicose veins
- ☐ edema
- ☐

Date of last ECG (if any):

_____

_____

Respiratory

- ☐ asthma
- ☐ tuberculosis
- ☐ bronchitis
- ☐ cough
- ☐ wheezing
- ☐ emphysema
- ☐ pneumonia
- ☐ shortness of breath with exertion
- ☐ shortness of breath with sitting
- ☐ shortness of breath with lying down
- ☐ pain with breathing

Date of last chest x-ray (if any):

_____

Gastrointestinal

- ☐ indigestion
- ☐ diarrhea
- ☐ constipation
- ☐ food intolerance
- ☐ abdominal pain
- ☐ heartburn
- ☐ ulcers
- ☐ hemorrhoids
- ☐ gas/bloating
- ☐ nausea
- ☐ vomiting
- ☐ liver disease
- ☐ hernias
- ☐ fatty meals bothering
- ☐ rectal bleeding/burning/itching

How often do you have a bowel movement?

_____

Date of last colonoscopy (if any):

_____

Allergic/Immunologic

- ☐ Seasonal allergies
- ☐ sensitivity to chemicals
- ☐ dry or itchy eyes
- ☐ asthma
- ☐ sinusitis
- ☐ hx of organ transplant or donation
- ☐ Sick often
- ☐ rash
- ☐ hives
- ☐ environmental chemical exposure
- ☐ have pets
- ☐ family hx of wheat allergy or celiac disease

Skin/Integumentary

- ☐ positive skin exam
- ☐ color change
- ☐ abnormal mole
- ☐ dry skin
- ☐ acne
- ☐ rash
- ☐ hives
- ☐ dandruff
- ☐ oily hair
- ☐ hair/nail changes
- ☐ psoriasis
- ☐ itchy skin
- ☐ rosacea
- ☐ eczema
- ☐ skin cancer
- ☐ warts
- ☐ dry hair
- ☐ hair loss

Neurological

- ☐ paralysis
- ☐ sciatica
- ☐ seizures
- ☐ weakness
- ☐ headaches
- ☐ migraines
- ☐ numbness/tingling
- ☐ tremors
- ☐ carpal tunnel
- ☐ fainting/blackouts
- ☐ dizziness
- ☐ lightheadedness

Mental/Emotional

- ☐ anxiety
- ☐ fear/panic
- ☐ eating disorder
- ☐ anger/irritability
- ☐ feeling down/depressed
- ☐ suicidal thoughts
- ☐ psychiatric hospitalization

Endocrine

- ☐ diabetes
- ☐ thyroid disease
- ☐ Mood swings
- ☐ Snacking often
- ☐ Irritability
- ☐ Hormone therapy
- ☐ increased urination
- ☐ increased thirst
- ☐ Hot/cold intolerance
- ☐ Needing to eat regularly
- ☐ Change in glove/shoe size

Hematologic/Lymphatic

- ☐ anemia
- ☐ easy bruising/bleeding
- ☐ hemorrhoids
- ☐ swollen lymph nodes
- ☐ circulation issues
- ☐ fragile/sensitive skin
- ☐ Hx of blood clots
- ☐ Deep bone pain
- ☐ Reaction to insect bites
- ☐ Brittle nails

LOCATION OF PAIN

Please mark the diagram below indicating the **TYPE** of pain(s)/sensations(s) you are having and the location on your body.

Please use the following symbols:

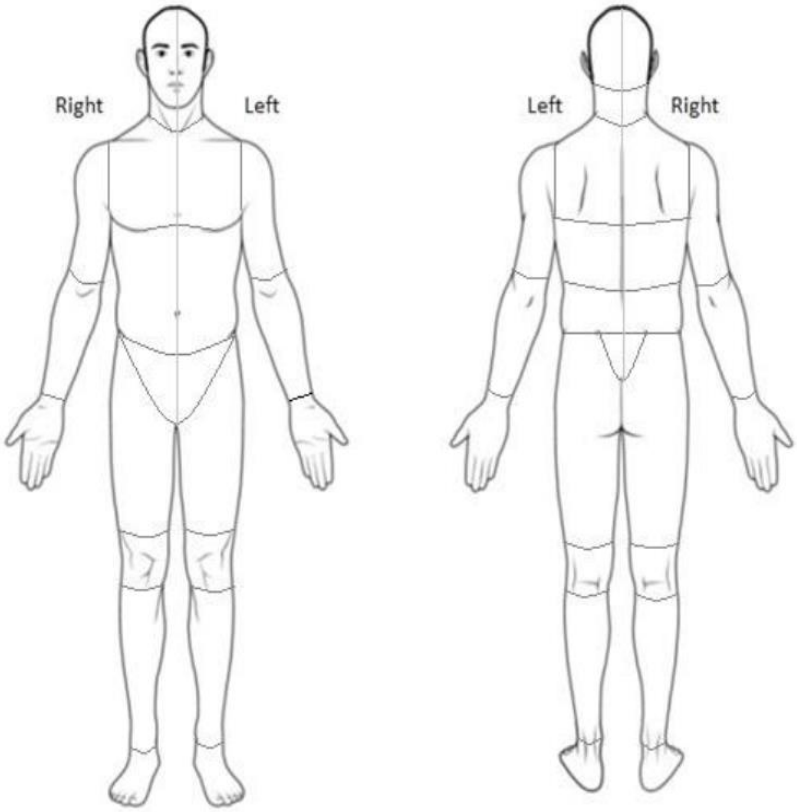
Solid Circles ● for **Stabbing Pain**

Open Circles ○ for **Pins & Needles**

Circles with X's ⊗ for **Numbness**

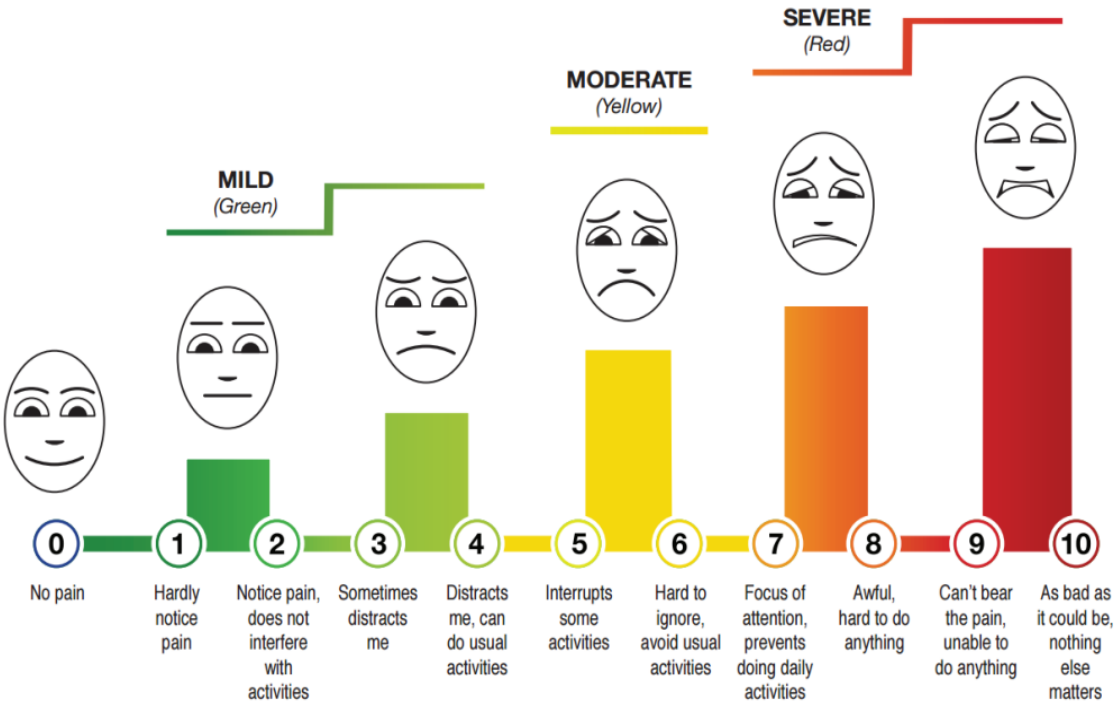
X's for **Burning Pain**

Triangles Δ for **Aching Pain**



PAIN SCALE

Circle (○) the number that describes your pain level on a ***GOOD*** day and place a square (☐) around the number that describes your pain on a ***BAD*** day.



MALE SECTION

(Only males complete this section)

Prostate / urinary symptoms?

- ☐ BPH
- ☐ nocturia
- ☐ prostatitis
- ☐ prostate cancer
- ☐ incomplete urination
- ☐ dribbling of urine
- ☐ difficulty initiating urination

Do you perform monthly testicular exams? ☐ Yes ☐ No

Date of your last PSA?

Date of your last prostate exam (digital rectal exam)?

Check all the pelvic symptoms you currently experience:

- ☐ testicular pain
- ☐ testicular swelling
- ☐ hernia
- ☐ penial discharge
- ☐ impotency
- ☐ decreased libido
- ☐ prostate disease
- ☐ rashes or skin changes

Contraception, Libido, and Sexually Transmitted Infections (STIs)

Are you currently sexually active? ☐ Yes ☐ No

Current number of sexual partners (if any):

Do you have sex with?

- ☐ Males
- ☐ Females
- ☐ Both males and females
- ☐ Other

Do you experience any of the following?

- ☐ low libido
- ☐ fertility challenges
- ☐ difficulty achieving an erection
- ☐ difficulty maintaining erection

Do you have a history of STIs?

☐ No ☐ Yes, indicate type:

How do you protect yourself from STIs?

Please indicate any hormones previously or currently used:

FEMALE SECTION

(Only females complete this section)

Menstrual Cycle

Age of first menses?

First day of last menses?

Length of menses?

Color of blood?

Clots in menses?
☐ Yes ☐ No

Number of pads/tampons used on your heaviest day?

Number of pads/tampons used on your lightest day?

Do you experience any of the following before or during your menses?

- ☐ diarrhea
- ☐ bloating
- ☐ food cravings
- ☐ mood changes
- ☐ headaches
- ☐ heavy bleeding
- ☐ menstrual cramping
- ☐ fatigue during menses
- ☐ backache during menses
- ☐ breast tenderness/ swelling

Breast Health

Do you do breast self-exams monthly?
☐ Yes ☐ No

Do you know how to perform a self breast exam?
☐ Yes ☐ No

Do you have any of the following?
- ☐ breast pain
- ☐ breast discharge
- ☐ breast masses

Date of last mammogram and results:

Gynecology and PAP History

Date of last PAP smear and results:

Have you ever had an irregular PAP smear?
☐ No ☐ Yes, list date and treatment received:

Check all pelvic disease conditions that you have a history of:

- ☐ ovarian cysts
- ☐ fibroids
- ☐ endometriosis
- ☐ ectopic pregnancy
- ☐ ovarian/uterine disease
- ☐ pelvic inflammatory disease
- ☐ other

Have you had any gynecological surgeries or procedures?
☐ No ☐ Yes, indicate date and type:

Any complications with pregnancy? ☐ Yes ☐ No

Any difficulty with conceiving? ☐ Yes ☐ No

Number of vaginal births:

Number of C-Sections:

Number of VBACs (vaginal birth after cesarean):

Contraception, Libido, and Sexually Transmitted Infections (STIs)

Are you currently sexually active? ☐ Yes ☐ No

Current number of sexual partners (if any):

Please indicate birth controls or other hormones previously or currently used:

Do you have sex with?
- ☐ Males
- ☐ Females
- ☐ Both males and females
- ☐ Other

Do you experience any of the following?
- ☐ low libido
- ☐ pain with intercourse
- ☐ bleeding after intercourse

Do you have a history of STIs?
☐ No ☐ Yes, indicate type:

How do you protect yourself from STIs?

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment in your home or any satellite location where Dr. Mitchell is able to render services. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, I encourage you to ask questions.

I voluntarily request a physician to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Signature of Patient or Personal Representative

_____

Date:

_____

ELECTRONIC COMMUNICATION CONSENT

Electronic communication such as email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls, but here are important differences.

Below are our rules for contacting us using e-mail.

E-mail is never, ever, appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Department for emergencies.

E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include prescription refill requests, referral and appointment scheduling requests and billing/insurance questions.

E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

E-mail is not confidential. It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.

E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.

E-mail is not a substitute for seeing me. If you think that you might need to be seen, please call and book an appointment!

I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

(Please initial consent option below)

Email Communications:

_____Yes, I have read this consent to E-Mail communication and want to communicate with my doctor/staff electronically.

_____No, I do not consent E-mail communication and do not want to communicate with my doctor electronically.

E-mail Reminders: _____Yes, I authorize appointment reminders electronically via E-mail to the e-mail address(s) listed below.

I understand that my contact information will not be sold to third parties.

_____No, I do not authorize appointment reminders electronically via E-mail. (continued on reverse)

Please complete all information below:

_____

E-mail Address

_____

Mobile Number

_____

I have fully read and understand the above consent and authorizations.

_____

Print Patient Name

_____

Patient or legally authorized individual signature

HIPAA NOTICE OF PRIVACY PRACTICES As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 our organization, 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 organization, 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. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

We may use or disclose your protected health information in the following situations without your authorization: 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, Criminal Activity, Inmates, Military Activity, National Security, and Workers’ Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services 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 this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: 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 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.

Our organization is not required to agree to a restriction that you may request. If our organization 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, e.g., electronically.

You may have the right to have our organization 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.

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 questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

_____

Signature of Patient or Personal Representative

_____

Date: