Internal and Family Medicine

Ana M. Sierra De Aragon, MD
Jesmina Shrestha, FNP-C
Jessica Diaz, FNP-C

INFORMACION DEL PACIENTE

Nombre Del Paciente: _____ **Fecha De Nacimento:** _____
Estado Cival: ☐Casodo/a ☐Soltero/a ☐Otro **Sex:** ☐Hombre ☐Mujer
NOMBRE DE LA PERSONA RESPONSIBLE (SI EL PACIENTE ES UN MENOR): _____
Race: ☐American Indian/Alaska Native ☐Asiatico ☐Nativo de Hawaii ☐Negro/Afro Americano
☐Blanco ☐Hispano ☐Otra Raza: _____
Ethnicity: ☐Hispano ☐Non-Hispano ☐Se Nego a Informar
Idoma: ☐Ingles ☐Espanol ☐Ruso/a ☐Indio (Hindi & Tamil) ☐Otro: _____
Domicilio: _____
Ciudad: _____ **Estado:** _____ **Codigo:** _____
Telefono de Casa: _____ **Celular/Texto:** _____
Correo Electronico: _____
Seguro Social del Paciente (SI ES MENOR, SEGURO DE PERSONA RESPONSIBLE): _____
Mensaje Detallado (CITAS, RESULTADOS DE LABORATORIO, ETC.) ☐Casa ☐Celular

Nombre del Seguro Medico Principal: _____
Group #: _____ **Member ID #:** _____
Policy Holder Name: _____ **Date of Birth:** _____
Nombre del Seguro Medico Secundario (SI APLICA): _____
Group #: _____ **Member ID #:** _____
Policy Holder Name: _____ **Date of Birth:** _____
Tiene un Testamento de Vida "Directiva del Cuidado de la Salud"? ☐Si ☐No
Tiene un Poder Medico del cuidado de la salud con autorizacion para la salud mental? ☐Si ☐No

CONTACTOS DE EMERGENCIA

Nombre del Contacto - Principal: _____
Relacion al Paciente: _____ **Telefono:** _____
Nombre del Contacto - Secundario: _____
Relacion al Paciente: _____ **Telefono:** _____

Como se entero de la officina de Internal and Family Medicine?
☐Amigo/a ☐Internet ☐Seguro ☐Trabajo ☐Periodico ☐Otro: _____

He leido y entendido las politicas del paciente y estoy de acuerdo en estar obligado por sus terminus. Tambien entiendo y estoy de acuerdo que tales terminus pueden ser modificados por la practica en cualquier momento y sin previo aviso. Entiendo que soy responsible de todos los cargos, independientemente de la coertura del Seguro. Estoy de acuerdo en pagar la cuenta, de acuerdo con los costos estandar y los plazos de pago de esta oficina. Autorizo Internal and Family Medicine para liberar los registros medicos a mi compania de seguros con el proposito de facturacion y cobro de las cuotas o monetarios. Autorizo a recibir mensajes de texto al numero(s) proporcionado.

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Firma de Persona Responsable (SI ES MENOR): _____ **Fecha:** _____

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HISTORIA MEDICA

Nombre Del Paciente: _____ **Fecha De Nacimento:** _____

HISTORIA MEDICA: MARQUE LAS QUE CORRESPONDAN

☐Ritmo Cardioaco Abnormal	☐Desmallos	☐Falla del Rinion	☐Enfermedad de Tiroides
☐Alergias	☐Fatiga	☐Enfermedad Pulmonal	☐Tonsiilitis
☐Asma	☐Gastritis	☐Pleurisy	☐Tuberculosis
☐Artritis	☐Dolor de Cabeza	☐Enfermeded Psychiatra	☐Fiebre Reumatica
☐Cancer	☐Problemas de Escuchar	☐Enfermedad del Corazon	☐Bipolar
☐Colesterol/Trigliceridos	☐COPD	☐Perdida de Escuchar	☐Ansiedad
☐Variaciones de Paso	☐Glaucoma	☐Fiebre Scarlet	
☐Desorientacion	☐Presion Alta/Baja	☐Estomago/Gastro	
☐Depresion	☐Influenza	☐Derrame Cerebral	
☐Diabetes	☐Golpes	☐Otro: _____	

Algun familiar tiene algunas condiciones de la lista anterior? Si es si, Cual es la relaion?

_____

Lista de edad o a la edad de fallecimiento y enfermedad que cada uno tiene/tenia y la causa de muerte.

Madre: _____ _____

Padre: _____ _____

Hermanos(as): _____ _____

ALERGIAS: ES ALERGICO A ALGUN MEDICAMENTO O ALIMENTO? FAVOR DE ESPECIFICAR:

_____ _____ _____

_____ _____ _____

FARMICIA: _____

Domicilio: _____ Numero de Telefono: _____

MEDICAMENTOS ACTUALES:

Tipo: _____ MG/Dosis: _____ Veces al Dia: _____

Tipo: _____ MG/Dosis: _____ Veces al Dia: _____

Tipo: _____ MG/Dosis: _____ Veces al Dia: _____

Tipo: _____ MG/Dosis: _____ Veces al Dia: _____

Tipo: _____ MG/Dosis: _____ Veces al Dia: _____

HISTORIA DE CIRUGIAS: LISTA DE CIRUGIAS Y FECHAS

_____ _____

_____ _____

_____ _____

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HISTORIA SOCIAL

Cual es su profesion actual? _____

Ha tenido alguno de los siguientes? MARQUE LAS QUE CORRESPONDAN

☐Alcoholism ☐Drogadiccion/Dependencia ☐Transfusiones ☐Enfermedad De Transmission Sexual (STD)

Fuma? ☐Si ☐No **Si, cuanto por dia?** _____ **Fumaba antes?** ☐Si ☐No

Cuando dejo de fumar? _____ **Cuanto por dia?** _____ **Cuanto anos:** _____

Consume alcohol? ☐Si ☐No **Tipo?:** _____ **Cuanto vasos:** _____

Hace ejercicio? ☐Si ☐No **Cuantas veces a la semana?** _____

Consume cafeina?: (cafe, te, soda, etc.) ☐Si ☐No **Cuantos vasos/tazas?** _____

CUIDADO DE LA SALUD

FECHA DE VACUNA:

Gripa: _____ **Pulmonia:** _____ **Hueso:** _____

Mammo: _____ **Examen de Ojos:** _____ **Immunization:** _____

AVISO AL PACIENTE

Internal and Family Medicine tiene una poliza de NO NARCOTICOS.
Ya no vamos a recetar narcoticos de uso de largo plazo/cronicas y benzodiazepinas o otros medicamentos adictivos a nuevos pacientes. (i.e. Norco, Vicodin, Xanax, Clonazepam, etc.)
Internal and Family Medicine NO ESCRIBE cartas para mascotas que ofrecen soporte emocional. Pacientes en busca de una carta para una mascota de soporte emocional seran referido a un psichiatra/psicologo.

La oficina de Internal and Family Medicine nos sentimos muy orgullosos de proveer servicios de calidad a nuestros pacientes.
Debido a que cada seguro de plan puede variar, entendemos que es la responsabilidad del paciente estar al tanto de cuanto es su deducible y co-seguro basado en el plan al cual usted, el paciente escoge con la compania de seguro.
Por lo tanto, mandaremos cobrar a su seguro medico por la visita y cualquier saldo respect al deducible o co-seguro se la mandara cobrar al paciente.
Apreciamos que el saldo de su cuenta sea pagado en suanto reciba la fracture para evitar cualquier balance atrasado.

Al firmar abajo, usted, el paciente acepta su responsabilidad de pagar cualquier deducible o co-seguro por los servisos recibidos en nuestra oficina.

Yo reconozco que eh leido y entiendo lo que esta escrito arriba.

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PRACTICAS DE PRIVACIDAD

Se me ha informado de como se puede acceder a mi informacion protegida, uso y divulgacion y entiendo que una copia de esta disponsible si la solicito.

Entiendo que, si yo quiero, las siguientes personas pueden tener acceso a mi expedienre clinic:

NOMBRE	RELACION AL PACIENTE	NUMERO DE TELEFONO

Firma de Paciente: _____ Fecha: _____

Firma de Persona Responsable (SI ES MENOR): _____ Fecha: _____

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Ana M. Sierra De Aragon, MD | Jesmina Shrestha, FNP-C | Jessica Diaz, FNP-C
3303 E. Baseline Rd. Suite 203 Gilbert, AZ 85234
P: 480.300.5388 | F: 480.999.5040

AUTORIZACION PARA PROVEER Y CONSENTIMIENTO PARA MOSTRAR ARCHIVO MEDICO

Nombre: _____ **Fecha de Nacimiento:** _____

Direccion: _____

Ciudad: _____ Estado: _____ Codigo Postal: _____

Numero de Celular: _____ Telefono de Casa: _____

PORFAVOR SELECCIONE SOLO UNA DE LAS SIGUIENTES OPCIONES:

_____ Autorizo Internal and Family Medicine **RECIBIR** el expediente clinico del proveedor indicado abajo.

_____ Autorizo Internal and Family Medicine **ENVIAR** el expediente clinico al proveedor indicado abajo.

Nombre del Medico &/O Clinica: _____

Direccion: _____

Ciudad: _____ Estado: _____ Codigo Postal: _____

Telefono: _____ Fax: _____

☐Todo el Archivo Medico ☐Referencia ☐Resultado de Laboratorio ☐EKG
☐Visitas a Emergencia ☐Uso/Abuso de Substancias ☐Rayos X ☐Nota de Progreso

Por la presente autorizo la entrega de copias de los siguientes registros médicos; y soy consciente del tiempo necesario de 72 horas hábiles después de que hayan cubiertos los cargos aplicables. A menos que se especifique lo contrario, los registros serán puestos en libertad en un formato seguro de documentos electrónicos. A los efectos del presente documento, "los registros médicos" incluirán todo. Por la presente libero, a mi medico/proveedor y sus empleados de cualquier responsabilidad por el cumplimiento de la solicitud de autorización para divulgar información médica. Este consentimiento es válido por máximo un año, o hasta que expresamente sea revocado por mí. Puedo revocar esta autorización en cualquier momento proporcionado notificación escrita a Internal and Family Medicine para tal efecto. Entiendo que cualquier comunicado que tuvieron lugar antes de mi revocación del acuerdo con esta autorización NO constituirá una violación de mis derechos de confidencialidad. Yo entiendo que un facsímil fotocopia de esta autorización se considera aceptable en lugar del original. Tratamiento medico no va a estar condicionado en que yo proporcione esta autorización; a menos que el único fin de la visita médica sea crear información de salud protegida para presentársela a un tercero. Una vez que esta información se libera, puede ser revelada por el recipiente y puede ya no considerarse información protegida, ni responsabilidad de esta oficina.

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POLIZA FINANCIERA

Esta poliza financiera es un element critico de su arreglo medico con Internal and Family Medicine. Por favor, lealo cuidadosamente; pues incluye razones por las que se le puede cobrar.

Yo estoy de acuerdo de que Internal and Family Medicine enviara cobro a mi seguro como una cortesia; sin embargo, yo soy responsible por todos los cargos incurridos.

Es mi responsabilidad entender mi seguro medico y verificar los beneficios. Tambien es mi responsabilidad verificar que la doctora esta en mi plan de seguro.

Es mi responsabilidad a notificar Internal and Family Medicine de cualquier cambio en mi olan de seguro, incluyendo direccion donde vivo.

Acuerdo pagar mi co-pago/deducible o co-seguro cada visita.

El seguro proveera a mi y a Internal and Family Medicine una EOB (Explicacion de Beneficios): Acuerdo en pagar lo que mi seguro, o servicios no cubiertos. Facturas se envian por correo cada mes y deben ser pagadas en cuanto sea notificado de lo que se debe. Puede haber cargos adicionales si se me tiene que notificar varias veces. Si despues de 3 notificaciones yo no pago la deuda total o si no se acuerda a un plan de pagos; entonces Internal and Family Medicine se reserve el derecho de mandame a una agencia de coleccion y agregar 33% a mi balance.

Yo soy responsible de pagar si:

--- No puedo vereficar mi seguro al momento de mi cita.
--- No tengo seguro medico.
- Pregunte por nuestro poliza de pago en efectivo.

--- Mi seguro no tiene contrato con Internal and Family Medicine..
--- Recibo un servico no cubierto en mi poliza de seguro.
--- Mi seguro niega los cobros por una razon que no se puede resolver.

Acuerdo pagar:

--- $50 si mi cheque personal es rechazado.
--- $50 por CANCELACION EL MISMO DIA de la cita.
--- $50 por NO PRESENTARME a mi cita.
- Puedo ser despedido de la oficina si tengo faltas frecuentes.

Balance delinquent mas de 60 dias:
Citas futuras no podran hacer agendadas hasta que el balance se page por complete o hasta que haga un plan de pago.

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POLICA DEL PACIENTE

Solicitamos su colaboracion y comprension para hacer una oficina viable, y para servirle major en su necesidades de salud a tiempo y de manera efectiva.

1. **Consultas a Especialista:**
   - Si su companaia de seguros require pre-autorizacion y manejos especiales:
     - Nos puede tomar hast 10 dias en completer ese proceso.
     - Proveeremos hasta dos refrencias por visita.
     - El asistente medico le llamara cuando su refrencia esta lista.

2. Preparese para su cita teniendo sus preguntas escritas, lista de medicinas que toma, tarjeta de seguro y su identificacion.
   - No todos los problemas de salud seran atendidos en una sola cita; de tal forma que otras visitas de seguimiento pueden ser necesarias.

3. Rellenos de medicinas pueden tardar hasta 1 semana. **Porfavor, plane apropiadamente.**
   - Solicitelas durante su visita; de otra forma, una cita nueva es necesaria.

4. **Si acaba de salir de un Hospital, usted debe de visitamos durante los primeros 3 a 7 dias que se le dio de alta.**
5. **NO debe de esperar mucho tiempo para visitamos.**

6. FALTANDO a su cita:
   - Pacientes que frecuentemente no se presentan pueden ser despedidos.
   - Se cobrara $50.00 a quien talte a su cita.

7. CANCELACION de citas:
   - Deben de hacerse por lo menos con 1 dia de anticipacipon.
   - Cancelaciones que se hacen el MISMO DIA pueden tener un cargo de $50.00.
   - Cancelaciones frecuentes pueden resultar en su despido de esta oficina.

8. Discharge
   - Pacientes que no siguen las instrucciones de la doctora o no cumplen sus medicinas pueden ser despedidos de esta oficina.
   - Pacientes en medicinas controladas seran evaluados tan frecuente como se considere necesario.
   - Pacientes agresivos que muestran falta de respect a la doctora o empleados seran despedidos.

9. Comentarios, quejas, sugerencias, clarificaciones, solictar excepiones:
   - Puede hablar directamente con la doctora. Tendra que esperar a que este disponible.
   - Correo Electronico: Feedback@InternalAndFamilyMedicine.com

Firma de Paciente: _____ Fecha: _____

Firma de Persona Responsable (SI ES MENOR): _____ Fecha: _____

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information This medical practice collects health information about you and stores it in a chart and in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of this business

Associates that contain terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written

authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made
to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or
Safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach.
22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of
HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again.
B. When This Medical Practice May Not Use or Disclose Your Health Information Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. You're Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice

Has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices'. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint as follows: The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Firma de Paciente: _____ Fecha: _____

Firma de Persona Responsable (SI ES MENOR): _____ Fecha: _____