

PATIENT INFORMATION

DATE _____ (PLEASE PRINT)

FIRST NAME _____ M.I. _____

LAST NAME _____ NICKNAME _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____

SOCIAL SECURITY# _____ SEX _____

DATE OF BIRTH _____ AGE _____

MARITAL STATUS: S M D W SPOUSES NAME _____

OF CHILDREN _____ HOME PHONE _____

OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____ WORK PHONE _____

CITY/STATE _____ ZIP _____

FAX OR 2ND PHONE _____ E-MAIL _____

DRIVER'S LICENSE # _____

PERSON RESPONSIBLE FOR PAYMENT _____

HOW WERE YOU REFERRED TO OUR OFFICE? FRIEND'S NAME _____

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? _____

IF YES, WHEN _____

IS THIS INJURY/ILLNESS WORK-RELATED? _____ HAVE YOU REPORTED IT TO YOUR EMPLOYER? _____

IS THIS INJURY/ILLNESS RELATED TO AN AUTOMOBILE ACCIDENT? _____

OR IS THIS CONDITION DUE TO AN: A) OTHER ACCIDENT B) UNKNOWN CAUSE C) ILLNESS

WHAT IS YOUR MAJOR COMPLAINT? _____

ARE THE SYMPTOMS: A) IMPROVING B) GETTING WORSE C) ABOUT THE SAME D) INTERMITTENT

DATE SYMPTOMS APPEARED _____ CIRCLE ANY ACTIVITIES WHICH AGGRAVATE YOUR CONDITION:

A) STANDING B) WALKING C) SITTING D) LYING E) BENDING F) LIFTING G) TWISTING

H) COUGHING I) OTHER _____

HAVE YOU HAD THESE SYMPTOMS BEFORE? _____ IF SO, WHEN? _____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION? _____ IF SO, WHAT SPECIALTY?

A) M.D. B) CHIROPRACTOR C) OSTEOPATH D) ACUPUNCTURIST E) DENTIST F) PODIATRIST

DR'S. NAME _____ DATE CONSULTED _____ DIAGNOSIS _____

*****PLEASE COMPLETE ALL APPLICABLE SPACES BELOW AND PRESENT YOUR CARD TO THE FRONT DESK*****

DO YOU HAVE ANY TYPE OF HEALTH INSURANCE? _____ PHONE # _____

INSURANCE COMPANY _____ ADDRESS _____

INSURED'S NAME _____ RELATION _____

INSURED'S DATE OF BIRTH _____ SS# _____

ARE YOU COVERED UNDER ANY OTHER HEALTH INS. POLICY THROUGH YOURSELF OR SPOUSE? _____

INSURANCE COMPANY _____ PHONE# _____

ADDRESS _____ INSURED'S SS# _____

INSURED NAME & DOB _____ RELATION _____

AUTO INSURANCE CO. _____ POLICY# _____

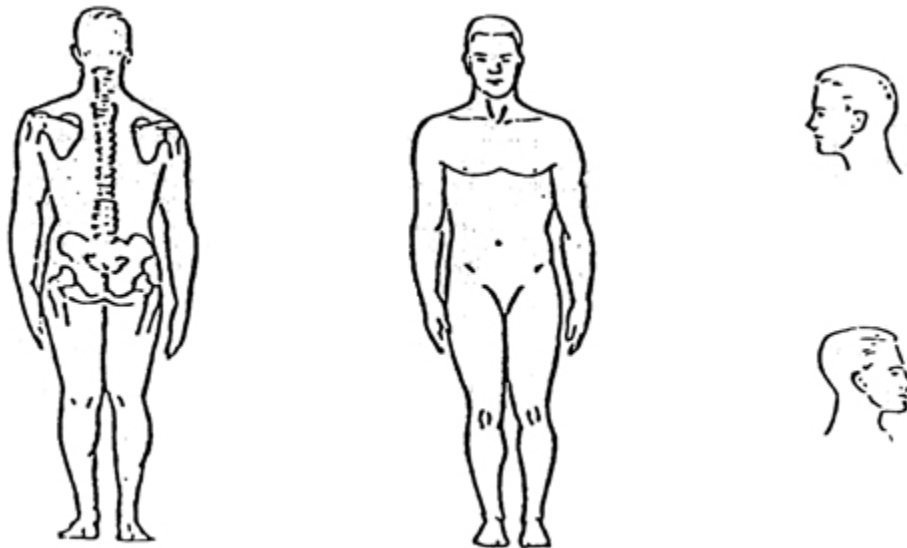
CLAIM# _____ PHONE# _____

ADDRESS _____ AGENT'S NAME _____

NAME OF ATTORNEY _____ ATTORNEY'S PHONE # _____

IF YOU ARE IN PAIN, PLEASE MARK THE EXACT LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW. ALSO DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN, AS WELL AS ANY ACTIVITY WHICH BRINGS ON OR AGGRAVATES THE PAIN, FOR EXAMPLE, DULL, SHARP, CONSTANT, OFF & ON, WHEN STANDING, WHEN SITTING, ETC.

COMPLETE THESE DIAGRAMS



METHOD OF PAYMENT YOU PLAN TO USE FOR TODAY'S CHARGES:

CHECK CASH VISA

PATIENT'S SIGNATURE: _____

ARE YOU HERE FOR FREE SCOLIOSIS OR SPANAL EXAM ONLY? YES NO

HEALTH HISTORY – Confidential

Patient Name _____

Today's Date: _____

Age _____ Birthdate _____

Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS – Check symptoms you currently have or have had in the past year.

<p>GENERAL</p> <ul style="list-style-type: none"> <input type="radio"/> Chills <input type="radio"/> Depression <input type="radio"/> Dizziness <input type="radio"/> Fainting <input type="radio"/> Fever <input type="radio"/> Forgetfulness <input type="radio"/> Headache <input type="radio"/> Loss of sleep <input type="radio"/> Loss of weight <input type="radio"/> Nervousness <input type="radio"/> Numbness <input type="radio"/> Sweats <p>MUSCLE/JOINT/BONE Pain weakness, numbness in:</p> <ul style="list-style-type: none"> <input type="radio"/> Arms <input type="radio"/> Hips <input type="radio"/> Back <input type="radio"/> Legs <input type="radio"/> Feet <input type="radio"/> Neck <input type="radio"/> Hands <input type="radio"/> Shoulders <p>GENITO-URINARY</p> <ul style="list-style-type: none"> <input type="radio"/> Blood in urine <input type="radio"/> Frequent urination <input type="radio"/> Lack of bladder control <input type="radio"/> Painful urination 	<p>GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="radio"/> Appetite poor <input type="radio"/> Bloating <input type="radio"/> Bowel Changes <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Excessive hunger <input type="radio"/> Excessive thirst <input type="radio"/> Gas <input type="radio"/> Hemorrhoids <input type="radio"/> Indigestion <input type="radio"/> Nausea <input type="radio"/> Rectal bleeding <input type="radio"/> Stomach pain <input type="radio"/> Vomiting <input type="radio"/> Vomiting blood <p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="radio"/> Chest pain <input type="radio"/> High Blood pressure <input type="radio"/> Irregular heart beat <input type="radio"/> Low blood pressure <input type="radio"/> Poor circulation <input type="radio"/> Rapid heart beat <input type="radio"/> Swelling of ankles <input type="radio"/> Varicose veins 	<p>EYE, EAR, NOSE, THROAT</p> <ul style="list-style-type: none"> <input type="radio"/> Bleeding gums <input type="radio"/> Blurred vision <input type="radio"/> Crossed eyes <input type="radio"/> Difficulty swallowing <input type="radio"/> Double vision <input type="radio"/> Earache <input type="radio"/> Ear discharge <input type="radio"/> Hay fever <input type="radio"/> Hoarseness <input type="radio"/> Loss of hearing <input type="radio"/> Nosebleeds <input type="radio"/> Persistent cough <input type="radio"/> Ringing in ears <input type="radio"/> Sinus problems <input type="radio"/> Vision – Flashes <input type="radio"/> Vision – Halos <p>SKIN</p> <ul style="list-style-type: none"> <input type="radio"/> Bruise easily <input type="radio"/> Hives <input type="radio"/> Itching <input type="radio"/> Change in moles <input type="radio"/> Rash <input type="radio"/> Scars <input type="radio"/> Sore that won't heal 	<p>MEN only</p> <ul style="list-style-type: none"> <input type="radio"/> Breast lump <input type="radio"/> Erection difficulties <input type="radio"/> Lump in testicles <input type="radio"/> Penis discharge <input type="radio"/> Sore on penis <input type="radio"/> Other <p>WOMEN only</p> <ul style="list-style-type: none"> <input type="radio"/> Abnormal Pap Smear <input type="radio"/> Bleeding between periods <input type="radio"/> Breast lump <input type="radio"/> Extreme menstrual pain <input type="radio"/> Hot flashes <input type="radio"/> Nipple discharge <input type="radio"/> Painful intercourse <input type="radio"/> Vaginal discharge <input type="radio"/> Other <p>Date of last menstrual Period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? ___ Y ___ N</p> <p>Are you Pregnant? ___ Y ___ N</p> <p>Number of children: _____</p>
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CONDITIONS – Check conditions you have or have had in the past.

<ul style="list-style-type: none"> <input type="radio"/> AIDS <input type="radio"/> Alcoholism <input type="radio"/> Anemia <input type="radio"/> Anorexia <input type="radio"/> Appendicitis <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Bleeding Disorders <input type="radio"/> Breast Lump <input type="radio"/> Bronchitis <input type="radio"/> Bulmia <input type="radio"/> Cancer <input type="radio"/> Cataracts 	<ul style="list-style-type: none"> <input type="radio"/> Chemical Dependency <input type="radio"/> Chicken Pox <input type="radio"/> Diabetes <input type="radio"/> Emphysema <input type="radio"/> Epilepsy <input type="radio"/> Glaucoma <input type="radio"/> Goiter <input type="radio"/> Gonorrhoea <input type="radio"/> Gout <input type="radio"/> Heart Disease <input type="radio"/> Hepatitis <input type="radio"/> Hernia <input type="radio"/> Herpes 	<ul style="list-style-type: none"> <input type="radio"/> High Cholesterol <input type="radio"/> HIV Positive <input type="radio"/> Kidney Disease <input type="radio"/> Liver Disease <input type="radio"/> Measles <input type="radio"/> Migraine Headaches <input type="radio"/> Miscarriage <input type="radio"/> Mononucleosis <input type="radio"/> Multiple Sclerosis <input type="radio"/> Mumps <input type="radio"/> Pacemaker <input type="radio"/> Pneumonia <input type="radio"/> Polio 	<ul style="list-style-type: none"> <input type="radio"/> Prostate Problem <input type="radio"/> Psychiatric Care <input type="radio"/> Rheumatic Fever <input type="radio"/> Scarlet Fever <input type="radio"/> Stroke <input type="radio"/> Suicide Attempt <input type="radio"/> Thyroid Problems <input type="radio"/> Tonsillitis <input type="radio"/> Tuberculosis <input type="radio"/> Typhoid Fever <input type="radio"/> Ulcers <input type="radio"/> Vaginal Infections <input type="radio"/> Venereal Disease
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<p>MEDICATIONS</p> <p>Pharmacy Name: _____ Phone: _____</p>	<p>ALLERGIES (To medications or substances)</p>
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All information is strictly confidential

FAMILY HISTORY						
Fill in health information about your immediate family.						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS		
Check (✓) which substances you use and describe how much you use.		
	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates: _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS		
Check (✓) if your work exposes you to the following:		
	Stress	
	Hazardous Substances	
	Heavy Lifting	
	Other	
Your occupation: _____		

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ Signature of Patient, Parent, Guardian or Personal Representative	_____ Date
_____ Please print name of Patient, Parent, Guardian or Personal Representative	_____ Relationship to Patient
_____ Reviewed By	_____ Date

Financial Policy

During the course of treatment by Advanced Comprehensive Medical, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, patient co-pays, deductibles and co-insurance will be your responsibility and are due at the time of service.

If your insurance carrier requires a "referral" from your primary care physician, you will need to contact your PCP for the referral. Treatment provided by this office without the required referral will serve as your consent for treatments not covered by insurance, and will be payable at the time of service.

- I certify that I have no insurance and will be solely responsible for payment in full.
- I certify that the insurance reported to Advanced Comprehensive Medical, is a complete listing. I understand the office will not extend credit on, or submit a claim for any insurance not reported at the time of service.
- I certify that charges will be protected by an LOP provided by my attorney. I also understand that, if for any reason, I no longer have attorney representation that I become fully responsible for all charges incurred.

I understand that any claim not paid by my insurance within 60 days from the date filed, will become my responsibility and payable upon billing.

Re: Divorce and Separated Parents

The adult accompanying the child (patient) shall be held responsible for that child's medical expenses, with payment expected at completion of the medical services.

It is NOT our office's responsibility to collect payment from the absent parent, even though that parent has been assigned responsibility of the child.

Authorization to release medical information.

I authorize Advanced Comprehensive Medical; to release any medical information requested by physicians or insurance companies regarding treatment at this facility.

Insurance Assignment

I hereby authorize payment to be made directly to Advanced Comprehensive Medical, by my insurance company for any charges for services covered by the terms of my policy. I agree to cooperate, aid and assist the facility in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

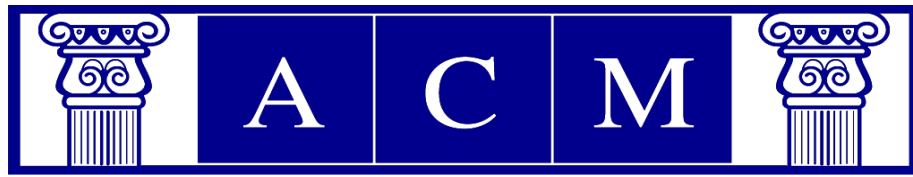
NOTE: Supplies are considered cash transactions and payable at the time of service. We do not bill insurance companies.

I have read and understand the above information and hereby authorize Advanced Comprehensive Medical to prescribe and provide treatment.

(Please Print) (Date) (Witness) _____

(Signature) (Date) _____

(Relationship to Patient)



ADVANCED COMPREHENSIVE MEDICAL

PARTIAL ASSIGNMENT OF THE CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS,
CONTRACTUAL LIEN, AND AUTHORIZATION
(Agreement)

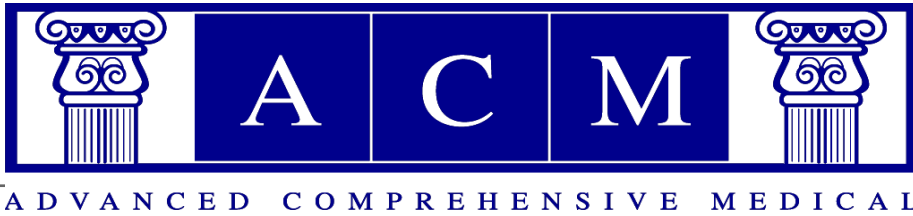
I hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities (A payer), which may elect, or be obligated, to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of Advanced Comprehensive Medical/Advanced Chiropractic North (“Advanced Comprehensive Medical”/or “Advanced Chiropractic North”, or “Office”) in the amount of full charges incurred by me at the office, past or future, including but not limited to, charges for treatment, narrative reports, dispositions, testimony, and any other charges incurred by me at the office (“my charges”). I further grant a contractual lien to Advanced Chiropractic Medical/Advanced Chiropractic North with respect to my charges; However, I understand that nothing in this Agreement shall be construed as an election by Advanced Chiropractic Medical/Advanced Chiropractic North to claim protection under any motorist coverage, liability coverage, property damage coverage, and malpractice coverage.

I further agree that, in the event a payer refuses to pay Advanced Comprehensive Medical/Advanced Chiropractic North, I hereby assign to the office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to Advanced Comprehensive Medical/Advanced Chiropractic North as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the Office’s name, and the right to settle or otherwise resolve such causes of action as the office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I directed each attorney to issue a letter of protection to Advanced Comprehensive Medical/Advanced Chiropractic North my charges. Upon Issuance, I agree that such letter(s) of protection cannot be revoked or modified without expressed written consent of the office. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the office regarding my funds received by the attorney relating to my accident, to promptly pay the office out of such funds, and to provide a full accounting of such funds to the office upon its request,

I hereby authorize and direct Advanced Comprehensive Medical/Advanced Chiropractic North Chiropractic to file my claims with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance of payment (e.g., liability, medpay, attorneys, etc.); I hereby authorize and direct Advanced Comprehensive Medical/Advanced Chiropractic North to collect any write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurance or source of payment..

I hereby direct all peers to release to Advanced Comprehensive Medical/Advanced Chiropractic North any pertinent information regarding any coverage I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize this Office to release my information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I hereby direct this office to file a copy of this agreement, together with my applicable charges, with any and all payers, regardless of whether a claim has been established with said payers. I hereby authorize Advanced Comprehensive Medical/Advanced Chiropractic North to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment for balances on charges incurred by me to any other outstanding still owed by my spouse, my dependents, regardless of whether these other charges are related to my condition or me.



I understand that I remain personally responsible for the total amounts due to Advanced Comprehensive Medical/Advanced Chiropractic North for these services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately responsible for payment and will reimburse Advanced Comprehensive Medical/Advanced Chiropractic North Chiropractic for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of Advanced Comprehensive Medical/Advanced Chiropractic North and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office, to the extent that the terms of those authorizations conflict with the terms of this agreement.

I agree that each and every provision of this agreement is responsibly necessary for the protection of the rights and interest of Advanced Comprehensive Medical/Advanced Chiropractic North and me. However, should any provision of this agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any part hereto, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Patient Name (Please Print): _____

Patients Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian (Please Print): _____

Parent/Guardian's Signature: _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various models of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its contents, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek Treatment

TO BE COMPLETED BY PATIENT

Patient's Name _____ (please print) Signature of Patient _____

Date Signed _____ Witness or Patient's Signature _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name _____ (please print) Signature of Patient _____

Date Signed _____ Signature of Representative _____

Relationship or Authority of Patient's Representative _____

Translated by _____ Date _____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic: Advanced Comprehensive Medical
Address: 832 West Spring Creek Parkway, Suite 300A, Plano, TX 75023

Name of Doctor's treating this patient: (please print)

1. _____ PIN# _____

2. _____ PIN# _____

3. _____ PIN# _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

Employee signature

Date

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 1, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, *Tanya Walsh*. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$ 0.25 for each page and the staff time charged will be

\$ 10.00 per hour, (with a minimum charge of \$5.00), including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (*Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.*)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. You will need to Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Advanced Comprehensive Medical

Privacy Officer: Nery Franco

Telephone: 972-424-4243

Fax: 972-424-6211

E-Mail: nery_franco@verizon.net

Address: 832 W. Spring Creek Parkway, Ste 300A, Plano, TX 75023