



RASOULI  
SPINE

### PERSONAL INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  Not working

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

### CURRENT PROBLEMS

Date symptoms began: \_\_\_\_\_

Chief complaint or reason for visit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cause of present problem (e.g. work related injury, auto accident, slip-and-fall, etc.): \_\_\_\_\_

\_\_\_\_\_

### PAST HISTORY

Please indicate any treatments you have tried for your current spinal problem:

Physical Therapy  Yes  No

Spinal Injections  Yes  No

Chiropractic Treatment  Yes  No

Other Treatments Tried \_\_\_\_\_

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):

*(If more space is needed, please attach on a separate sheet.)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Previous Surgeries**

Name of operation

Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Information**

Do you smoke?  Yes  No

Number of cigarettes per day \_\_\_\_\_

Do you drink alcohol?  Yes  No

Number of drinks per day \_\_\_\_\_

Do you use recreational drugs?  Yes  No

Please specify \_\_\_\_\_

Have you had imaging in the last 3 months?

Yes  No  MRI  CT Scan  X-rays

**Allergies**

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

Drug name

Reaction

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications**

Please list all current medications, over the counter drugs, vitamins and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

Name

Dosage / Amount

Time of day

Total taken in 24 hours.

Name	Dosage / Amount	Time of day	Total taken in 24 hours.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**REFERRING PHYSICIAN**

Name: \_\_\_\_\_ (LAST, FIRST)

Specialty: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

**INTERNIST / PRIMARY PHYSICIAN**

Name: \_\_\_\_\_ (LAST, FIRST)

Specialty: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

**OTHER PHYSICIAN INVOLVED IN YOUR CARE**

Name: \_\_\_\_\_ (LAST, FIRST)

Specialty: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

**WORKERS' COMPENSATION (IF APPLICABLE)**

Carrier Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ (LAST, FIRST)

Phone: (    ) \_\_\_\_\_ Email: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



## V. PATIENT ACKNOWLEDGEMENT OF RISKS ASSOCIATED WITH OPIOID USE

I acknowledge that I have been informed of and understand the risks associated with the use of opioid medications as outlined below. These risks have been explained to me in a clear and understandable manner, and I have had the opportunity to ask questions and discuss these concerns with my healthcare provider.

- 1. Risks of Addiction and Overdose:** I understand that the use of opioid medications carries a risk of addiction, overdose, and death, even when taken as prescribed. I am aware that opioids can be habit-forming, and prolonged or improper use may lead to physical and psychological dependence.
- 2. Increased Risk for Individuals with Mental Health and Substance Use Disorders:** I have been informed that individuals with a history of mental health disorders (such as depression, anxiety, or post-traumatic stress disorder) or substance use disorders (including alcohol or drug abuse) are at a significantly higher risk for developing an addiction to opioids. I understand that if I have or have had any of these conditions, I may be at an even greater risk for opioid misuse and overdose.
- 3. Danger of Combining Opioids with Other Substances:** I have been made aware of the dangers of taking opioid medications in combination with other substances that affect the central nervous system, such as benzodiazepines (e.g., Xanax, Ativan, Valium), alcohol, or other sedatives. I understand that mixing opioids with these substances can significantly increase the risk of life-threatening respiratory depression, overdose, and death.

I acknowledge that I have received this information, understand the risks involved, and am aware of the importance of following the prescribed dosage and directions. I will not alter my dosage, combine opioids with other substances, or share my medication with others. I also understand that if I experience any concerning symptoms, such as difficulty breathing, extreme drowsiness, or confusion, I should seek emergency medical attention immediately.

Signature

Date

Print Name

## OPEN PAYMENTS DATABASE NOTICE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>. ”

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
TO DESIGNATED INDIVIDUALS**

In accordance with HIPAA privacy regulations, you may authorize our office to discuss your medical information with another person of your choice (a spouse, parent, child, etc)

Please list anyone you wish to authorize:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Type of access:

- Appointment information
- Medical information
- Billing/insurance

I do not authorize this office to release information to anyone other than myself.

This authorization will remain in effect until I provide written notice of change.

Signature

Date

\_\_\_\_\_

\_\_\_\_\_



## AUTHORIZATION TO COMMUNICATE VIA ELECTRONIC MEANS

Our office prefers the efficiency and convenience of electronic communication. We may send you office reminders, test results, and surgery instructions via the electronic method you prefer. Please be advised that communicating via email is not secure communication.

I understand that RasouliSpine does not and cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentiality caused by me or a third party. I understand that RasouliSpine has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient. I understand that any changes to this disclaimer need to be communicated in writing.

If you agree to communicate with us electronically, please acknowledge this form below.

Thank you.

Signature

Date

---

---



## MESSAGING CONSENT

I consent to receive SMS text messages from RasouliSpine for appointment reminders, marketing messages, and general two way communication. I am aware that text messaging is not a Health Insurance Portability and Accountability (HIPAA) compliant means of communication with RasouliSpine regarding my care. I understand this means my privacy can not be fully protected or guaranteed with means of communication. Understanding this, should I choose to communicate with RasouliSpine by text messaging before, after or during their care for me as a patient, I give RasouliSpine permission to respond with a text message in return. Message frequency varies. Message and data rates may apply. You may reply HELP for support. You may reply STOP to opt out. See our privacy policy for more information.

Terms and Conditions (Terms of Service)

Effective Date: \_\_\_\_\_

By opting to receive SMS messages from RasouliSpine, you agree to the following terms:

1. SMS Messaging Service

By providing my phone number, I consent to receive SMS text messages from RasouliSpine for appointment reminders, marketing messages, and general two-way communication. Messaging frequency varies. Message and data rates may apply. Reply HELP for support. Reply STOP to opt out.

2. Message Frequency

You will receive approximately 2-3 messages per month regarding your appointments.

3. Message and Date Rates

Message and data rates may apply based your mobile carrier's terms.

4. Privacy Policy

Your information will be handled in accordance with our Privacy Policy which can be found on our website at [www.rasoulispine.com](http://www.rasoulispine.com).

5. Opt-Out Instructions

You can opt out at any time by replying "STOP" to any SMS message. Reply HELP for support. You can also contact us directly at (310)421-0066.

6. Liability

We are not responsible for any charges, errors or delays in SMS delivery caused by your carrier or third party service providers.

By opting in, you confirm that you are the owner or authorized user of the phone number provided and that you are at least 18 years old.

Patient Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



## Telehealth Consent Form

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Telehealth may include the use of interactive audio, video, or other telecommunications technology.

I understand that telehealth services may include consultation, diagnosis, treatment, follow-up, and/or patient education. These services may be provided using secure video conferencing, telephone communication, or other electronic means.

I understand that the potential benefits of telehealth include improved access to care, convenience, reduced travel time, and the ability to receive timely medical evaluation and recommendations.

I understand that there are potential risks associated with telehealth, including but not limited to:

- Technical failures, interruptions, or poor image/sound quality
- Limitations in the provider's ability to perform a physical examination
- Potential delays in diagnosis or treatment due to these limitations
- Rare risks to the privacy or security of my health information despite reasonable safeguards

I understand that telehealth may not be appropriate for all medical conditions and that my provider may recommend an in-person visit when necessary.

I understand that the same confidentiality protections that apply to in-person care apply to telehealth services. My information will be handled in accordance with applicable privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA) and California law.

I agree to:

- Provide accurate and complete medical information
- Ensure I am in a safe, private environment during the telehealth visit
- Minimize distractions and interruptions
- Notify my provider if I do not understand the information provided

I understand that telehealth services are not intended for emergency situations. If I am experiencing a medical emergency, I will call 911 or go to the nearest emergency room.

I understand that I have the right to withdraw my consent to telehealth services at any time without affecting my right to future care or treatment.

---

Patient's Signature

---

Date

## RASOULISPINE CANCELATION POLICY

At RasouliSpine, we sched our appointments with the desire that each patient receive adequate time with our physicians and staff. It is important that you attend your scheduled appointment and arrive on time at the office.

To help our patients remembers their scheduled appointments, RasouliSpine sends text messages and email reminders in advance of their appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate other patients who are waiting for an appointment.

As a courtesy to our office, please give us at least a 48 hours notice of cancellation. If you do not cancel or reschedule your appointment with at least 48 hours notice, we may impose a “no show” service charge to account of \$300 for consultations and \$150 for follow-up visits.

This “no-show” charge will be billed directly to your account and is not reimbursable by your insurance company. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the “no-show” policy of RasouliSpine and agree to provide a credit card number, which may be charged \$300 for consults and \$150 for follow-ups. I understand that I must cancel or reschedule any appointment at least 48 hours in advance to avoid a potential “no-show” charge to the credit card provided.

Signature

Date

## FORMS POLICY

To Our Patients,

Our goal is to restore your quality of life. We are committed to your recovery and have a deep understanding of the various life and career concerns that are involved in recovering from spinal surgery. It is our pleasure to assist you with any letters and forms you may require. However, due to the heavy administrative resources involved in completing these forms and letters, there must be a nominal charge. We hope you understand the necessity of these fees. Please feel free to reach out to our office with any questions you might have.

### Form Fees

Initial State Disability Form	\$100
State Disability Extension	\$50
Employer/Private Insurance Form	\$100
Letters (jury duty, work notes, miscellaneous)	\$50
DMV Placard	\$50

Signature

---

Date

---

Time

## MEDICATION POLICY

We are committed to your comfort, and we understand that pain medications such as narcotics and muscle relaxants may be a necessary part of the recovery process. However, due to the passing of the Controlled Substances Act (CSA) along with the US Drug Enforcement Administration (DEA) and Department of Justice (DOJ) implementing stronger regulations on prescription medications, we are unable to prescribe or refill medications of any kind to patients who have not undergone a surgical procedure within the last 90 days. New patients may receive a first-time courtesy prescription if medically necessary. Unfortunately, our office cannot perform prior authorizations for these medications.

For patients whose pain medications fall outside of our policy; we suggest consulting with a pain management doctor. Please contact our office if you would like a referral.

The CSA places substances with accepted medical uses into one of five schedules: substances with the highest potential for harm and abuse are placed in Schedule II, while substances with progressively less potential for harm and abuse are placed in schedules III-V. (Schedule I is reserved for those controlled substances with no currently accepted medical use and lack of accepted safety for use.)

We apologize for any inconvenience this may cause. Please feel free to reach out to our office with any questions.

Signature

Date

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**1. Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating 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. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

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

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose 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 such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

**Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

**Facility Directories:** Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

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 laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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 health care 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.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Consumer information is not shared with third-parties for marketing purposes.

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 electronically.

## **3. 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 Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

Signature

Date