**AZ Physical Medicine & Rehabilitation, PC**
**5690 W. Chandler Blvd. Ste. 2**
**Chandler, AZ 85226**
**480-878-7425**

# Notice of Privacy Practices and Communication Consent

Patient Name:________________________________ DOB:______________
Please Print

Name and Phone number of Family Physician:

________________________________ (______)______________

Please list below the pharmacy you use including address or cross streets:

__________________________________________________________

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

**Can we leave detailed or confidential messages on your home phone? Yes No**

Home number: (________)____________________________

**Can we leave detailed or confidential messages on your cell phone? Yes No**

Cell Phone: (________)____________________________

**Can we mail test results to your home? Yes No**

Mailing address: ______________________________________________

Email address: ______________________________________________

**Emergency Contact Information:**

Name: __________________________ Relation: ____________________

Phone number: __________________________

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSE ND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

## PLEASE REVIEW IT CAREFULLY.

### Uses and Disclosures:

**Treatment:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Insurance Companies:** As a courtesy to our patients, we will verify and file your insurance claim, HOWEVER, we cannot guarantee payment by the insurance company. It is your responsibility to read your policy manual as it pertains to specialist and physical therapy coverage. Many insurance companies have stipulations, such as usual and customary rates, written referral requirements, limitation to number of therapy visits, limitations to reimbursable amounts per session, deductibles, coinsurance portions, co-payments, limits on supplies, etc. Such stipulations should be indicated in your policy manual, if not, we recommend that you contact your insurance company directly. YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED BY YOUR INSURANCE. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan accordingly. Benefits will be verified for Workers' Compensation and Automobile Accident Claims, however, this does not guarantee payment. In the event of denial or exhaustion of benefits, this account becomes your responsibility.

**Payment:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services, the services provided, and the medical condition being treated.

**Health care operations:** Your health information may be used as necessary to support the day-to-day activities. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement:** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures require your authorization:** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

## Additional Uses of Information:

**Appointment reminders:** Your health information will be used by our staff to send you appointment reminders.

**Information about treatments:** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

**Individual rights:** You have certain rights under the federal privacy standards. These included:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy you protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

## Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

## Right to revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in or policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

## Requests to Inspect Protected Health Information:

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by

contacting the office manager and/or staff member. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

## Complaints:

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Mohammad I. Uddin, MD, FAAPMR**
**AZ Physical Medicine and Rehabilitation, PC**
5690 W. Chandler Blvd. Ste. 2
Chandler, AZ 85226

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

## Contact Person:

The name and address of the person you can contact for further information concerning our privacy practices is:
**Mohammad I. Uddin, MD, FAAPMR**

Print Patient Name:________________________________________________

Patient Signature:______________________________ Date:_______________

Witness Signature:______________________________ Date:_______________