Notice of Privacy Practices and Patient Rights

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW ***ADVANCED HEALTH & WELLNESS LLC*** MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY. Protected health information means any information that may identify you and that relates to your past, present, or future health care treatment, services, or payment.

Treatment

We may use and disclose your health information to provide you with health care- related services or products, or we may share your health information with those involved in your health treatment.

Payment We may use or disclose your health information to bill and collect payment for the health care-related services or products that we provide to you. This includes determining eligibility or coverage, billing for services rendered and collections. Unless you have asked that we not bill your insurer or health plan, we may complete a claim form that contains your health information to obtain payment from your insurer or health plan.

Health Care Operations

We may use or disclose your health information for the purposes of Advanced Health & Wellness LLC, operations, which are activities that support Advanced Health & Wellness normal business operations.

There are some services provided through contracts with business associates. We may give limited access to your health information to our business associates so they can perform services to support our business. Our business associates are required by contract to safeguard your health information.

Disclosures That May Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your health information without your written authorization. These situations include:

- When required or permitted by law to do so, such as reporting your health information to state, federal, or local law enforcement officials, court officials, or government agencies, such as the FDA.
- When ordered by authorized public health officials for the purpose of carrying out public health activities, such as to report product problems, or exposure to a communicable disease.
- When the use/disclosure relates to victims of abuse, neglect or domestic violence.
- When the use/disclosure is for health oversight activities, such as by written request of a state/federal government agency performing management audits, financial audits, and program monitoring.
- When the use/disclosure is for judicial and administrative proceedings, such as in response to an order of a court. When the use/disclosure is to provide notification and reporting of an unsecured breach as required by law.
- When the use/disclosure is for law enforcement purposes, such as reporting certain types of wounds or injuries, or if there is a good faith belief the disclosure is necessary to prevent or lessen a serious, imminent threat to the safety of a person or the public.
- When the use/disclosure is related to death, such as disclosing your health information to coroners, medical examiner and funeral directors so they can carry out their duties related to your death.
- When the use/disclosure is related to cadaveric organ, eye, or tissue donation purposes.
- When the use/disclosure relates to military, national security, or incarceration/law enforcement custody purposes. We may disclose information about you for military activities, national security and intelligence activities, and for protective services to the President of the United States. We may disclose information about you to a correctional institution having lawful custody of you.
- When the use/disclosure relates to workers' compensation. We may disclose your health information as authorized by and to the extent necessary to comply with the laws related to workers' compensation or other similar programs established by law.
- When the use/disclosure relates to certain research purposes. For example, in limited circumstances, we may disclose your information to researchers preparing a research protocol or if an institutional review board determines authorization is not necessary.

Disclosures That Require Your Authorization

The following uses and disclosures of Protected Health Information will only be made pursuant to us receiving a written authorization from you:

- Uses and disclosure of your Protected Health Information for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of Protected Health Information under HIPAA; and
- Other uses and disclosures not described in this notice.

Marketing

We must obtain your written authorization prior to using your Protected Health Information for purposes that are marketing under the HIPAA privacy rules. For example, we will not accept any payments from other organizations or individuals in exchange for making communications to you about treatments, therapies, health care providers, settings of care, case management, care coordination, products, or services unless you have given us your authorization to do so or the communication is permitted by law.

We will not make any disclosure of Protected Health Information that is a sale of Protected Health Information without your written authorization.

You have the right to revoke authorization. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. Please submit your written revocations to the Privacy Officer at the address below. However, any revocation will not apply to disclosures or uses already made or taken in reliance on the authorization.

Your Rights Under Federal and State Privacy Regulations. The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). In addition, each State may have its own laws and regulations pertaining to information privacy. These regulations create certain rights that you may exercise regarding your health information.

You have the right to inspect and copy your protected health information. If you request copies, we will charge you a reasonable fee for copies. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health in

formation that is subject to laws that prohibit access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations (except as required by law). 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 your notification purposes as described in this Notice of Privacy Practices. Your request must be in writing, state the specific restriction requested and to whom you want the restriction to apply. Advanced Health & Wellness LLC, will consider such requests but is not required to agree to them, except in limited circumstances which we will explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

If you have paid for health care item or service “out of pocket” in full and in advance, and you request that we not disclose protected health information related solely to those items or services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information: was not created by this organization; is not available for inspection because of an appropriate denial; or if the information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your health information record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made, and tell others that we now have the incorrect information. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Complaints

You can file a complaint with the U.S. Department of Health of Human Services for Civil Rights by sending a letter to:
U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W. Washington, D.C. 20201
1.877.696.6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

You may also contact the government agency in your State tasked with promoting and protecting the privacy rights of individuals.

Diana Holte, APRN Kellie Chacanaca, APRN

3729 N. Crossover Rd. Suite #107
Fayetteville, AR. 72703
Phone: 479-595-8676
Fax: 479-935-8984

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number : _____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/___

Advanced Health and Wellness

Diana Holte, APRN

Kellie Chacanaca, APRN

PATIENT INFORMATION – Please Print

Date:_____

Name _____

Gender: __ M __ F Date of Birth _____SSN _____-_____-_____

Address:_____Apt#_____

City:_____ State:_____ Zip_____

Home Phone:_____ Cell _____

Preferred Contact: *(circle one)* **Home Work Cell Email _____**

Employer: _____ Work Phone: _____

Martial Status: *(circle one)* **Single Married Widowed Divorced Partner**

Race: *(circle one)* **White African American Asian Native Hawaiian/Pacific Islander Native American Indian/Alaskan Other Race: _____ Preferred Language _____**

Preferred Pharmacy:_____

Appointment Reminder: Please select how you would like to be notified of your appointment. You may select more than one option. *(circle one)*: **Email Text Phone Call**

*Messages and data rates may apply for text messages. To change your preferences at anytime, you may fill out an Appointment Reminder form at the receptionist desk.

SPOUSE or PARENT (if minor) INFORMATION

Name: _____ Date of Birth _____ Social Security _____

Employer _____Address _____Phone _____

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact _____Relationship _____

Phone_____Address_____City_____State____Zip _____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have read and acknowledged the Patient Notice of Privacy Practices from Advanced Health and Wellness.

Do you wish for a copy of the Patient Notice of Privacy Practices? Yes No

SIGNATURE _____DATE _____

In the event this Acknowledgment form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number, and relationship to the patient here.

My self/My Spouse (skip to the next section) OR:(list Father, Mother, Guardian or other)

PERSON RESPONSIBLE PARTY FOR PAYMENT

Name:_____ DOB: _____

Address:_____

City:_____ State:_____ Zip:_____

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist

Medicare Medicare No. _____-_____-_____-_____ Effective Date _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Health and Wellness for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

_____

PRIMARY INSURANCE_____

ID #_____ GP# _____ Phone# _____

Policy Holder's Name_____ DOB_____ SS#_____

Relationship to Policy Holder: *(Circle one)* **Self Spouse Child Step-Child Other:**_____

SECONDARY INSURANCE_____

ID#_____ GP#_____ Phone# _____

Policy Holder's Name_____ DOB_____ SS#_____

Relationship to Policy Holder: *(Circle one)* **Self Spouse Child Step-Child Other:**_____

INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I hereby authorize Advanced Health and Wellness to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance. I agree to pay any co-pay and amount due at the time of service. Further, I agree to be responsible for any and all cost of collection to include court costs and a reasonable attorney fee.

Signed _____Date _____

HOW DID YOU HEAR ABOUT US?

- Recommended by a friend or family member
- Clinic web site, www.dicksonstclinic.com
- E-mail, Facebook or Twitter
- Signs or location
- My employer

Other: *Please specify* _____

Thank you for choosing Advanced Health and Wellness.

Please complete the information below to help your doctor evaluate your health.

Name _____ Date_____ Date of Birth_____

What brought you today? _____

Do you feel that you are basically healthy? *(circle one)* **Yes** **No**

Mark any diseases known to have occurred in the family with the appropriate initial: **M** (Mother), **F** (Father), M**GM** (maternal grandmother), PGM (paternal grandmother), M**GF** (maternal grandfather), PGF(paternal grandfather) , **A** (aunt), **U** (uncle), **C** (cousin), **B** (brother), **S** (sister).

Alzheimer		Cancer		Hearing Prob.		Obesity	
Asthma		Stroke		Cholesterol		Blood Clots	
Alcoholism		Depression		High Blood Pressure		Kidney Prob	
Blood Disease		Developmental Problems		Mental Disease		Seizures	
Coronary Artery Dis		Diabetes		Migraines		Sickle Cell	

About You:

Education:*(circle one)* **Elementary** **High School** **GED** **College** **Graduate School** **Tech School**

Occupation_____ *(circle one)* **Single** **Married** **Widowed** **Divorced**

Tobacco Use: Type: *(circle one)* **Cigarettes** **Smokeless Tobacco**

Current -Everyday, how many ppd? _____ Current -occasional, how much?_____

Former, how many ppd? _____ Year started_____ Year Quit_____ Never _____

Alcohol Use: *(circle one)* **Yes** **No** Formerly How much and often? _____

Illicit drug use:*(circle one)* **Yes** **No** Formerly Please list_____

Allergies: Medicines _____Other _____

Medications: *Please list medications you take regularly.*

Over the Counter (Include vitamins and supplements) :_____

_____

Prescription: _____

_____

_____

_____

Medical Conditions: _____

_____

_____

Operations *(Please include where and when)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please mark "yes" to anything you have experienced recently or frequently:

	Y	N	When		Y	N	When
General:				***Gastrointestinal:***			
Feel anxious, depressed, or irritable							
Nervous breakdown				diarrhea			
Fever, Chills, Night Sweats				Frequent indigestion or gas			
Skin:				***Genitourinary:***			
Skin Rashes				Blood in urine			
Eyes, Ears, Nose, Throat:				Burning when you pass urine			
Severe or frequent headaches				Sexually transmitted disease			
Hearing trouble				***Musculoskeletal:***			
Goiter or thyroid trouble				Arthritis			
Vision trouble				**Health Changes:**			
Respiratory:				Has your weight changed in the past year?			
Shortness of breath				Approximate weight 1 year ago_____			
Asthma				***Other:***			
Cough				Excessive thirst			
Cardiovascular:				Swollen glands			
Heart trouble Pain in chest				Hay fever or allergies			

For Women

Are you currently pregnant? *(circle one)* **Yes** **No** Pregnancies(#):_____ Miscarriages:_____

Living children: _____ Age when menstrual periods began _____

Patient Signature_____Date_____