

# CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

DATE \_\_\_/\_\_\_/\_\_\_

**PATIENT INFORMATION:**

FULL NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_ MALE  FEMALE   
 ADDRESS \_\_\_\_\_ SSN# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME PHONE (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
 CELL PHONE (\_\_\_\_)\_\_\_\_-\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
 EMPLOYER'S NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 WORK PHONE (\_\_\_\_)\_\_\_\_-\_\_\_\_ EXT. \_\_\_\_\_ DATE SYMPTOMS BEGAN \_\_\_/\_\_\_/\_\_\_  
 MARITAL STATUS: SINGLE  MARRIED  WIDOWED  HOW DID YOU HEAR ABOUT US? \_\_\_\_\_  
 EMERGENCY CONTACT \_\_\_\_\_ PHONE (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

**AUTHORIZATIONS:**

- A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL HISTORY**

Have you been treated for any conditions in the past year?  NO  YES

If yes, please describe \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

Have you had x-rays taken?  NO  YES If yes, where? \_\_\_\_\_

What medications are you taking and for what conditions? (please list dosage and amounts)

What vitamins, minerals, or herbs do you currently take? (please list for what conditions, dosage, and frequency)

<b>HAVE YOU EVER:</b>	NO	YES	Briefly Explain
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
Been diagnosed with any condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	
Had sprains/strains?	<input type="checkbox"/>	<input type="checkbox"/>	

**HEALTH AND ILLNESS HISTORY**

<input type="checkbox"/> Alcoholism <input type="checkbox"/> Arthritis <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cold Extremities <input type="checkbox"/> Diabetes <input type="checkbox"/> Double Vision <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Loss of taste <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Poor Posture <input type="checkbox"/> Sinus Infection  <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Vomiting	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Bruise easily <input type="checkbox"/> Constipation <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Ears Ring <input type="checkbox"/> Fatigue <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Loss of memory <input type="checkbox"/> Neck Pain or Stiffness <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Prostate Trouble <input type="checkbox"/> Sleep problems or Insomnia <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Ulcers <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Anemia <input type="checkbox"/> Back pain <input type="checkbox"/> Cancer <input type="checkbox"/> Cramps <input type="checkbox"/> Digestion Problems <input type="checkbox"/> Excessive Menstruation <input type="checkbox"/> Fever <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Loss of balance <input type="checkbox"/> Nervousness <input type="checkbox"/> Pacemaker <input type="checkbox"/> Sciatica <input type="checkbox"/> Slurred speech  <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Varicose Veins Other	<input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Breast lump <input type="checkbox"/> Chest pain/conditions <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Eye pain or difficulties <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Loss of smell <input type="checkbox"/> Night Sweats <input type="checkbox"/> Polio <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Spinal Curvatures  <input type="checkbox"/> Thyroid Condition <input type="checkbox"/> Venereal Disease
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Do you experience pain every day?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Do your symptoms interfere with daily life?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Does pain wake you up at night?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Are your symptoms worse during certain times of the day?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Do changes in weather affect your symptoms?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Do you wear orthotics?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Do you take vitamin supplements?	<input type="checkbox"/> NO	<input type="checkbox"/> YES
What activities aggravate your symptoms?		

<b>HABITS</b>	<b>None</b>	<b>Light</b>	<b>Moderate</b>	<b>Heavy</b>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## HOW CAN WE HELP YOU?

What brings you in today? \_\_\_\_\_

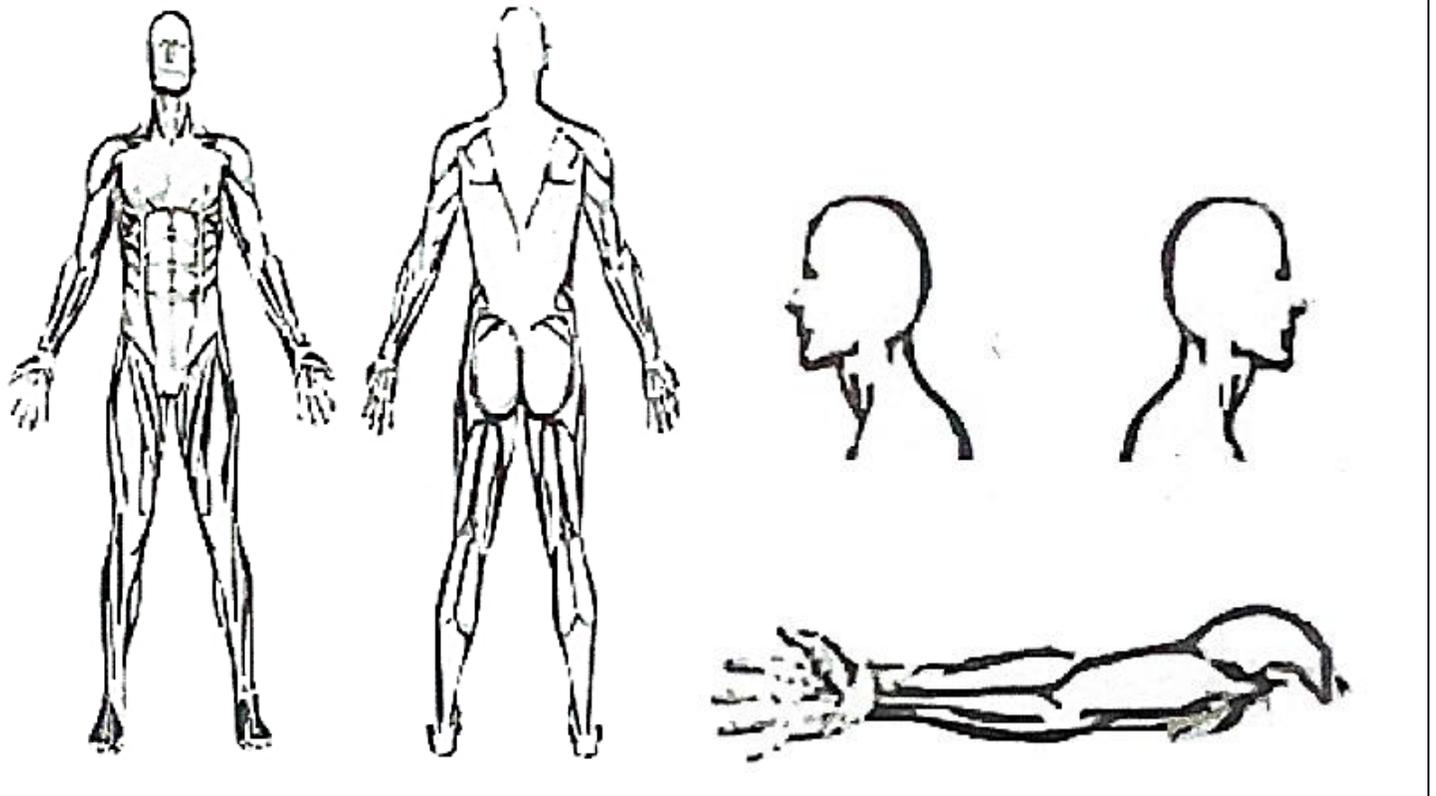
If you are already experiencing a symptom, what is it? \_\_\_\_\_

How bad is it? How intense are your symptoms? (circle) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩  
 No symptoms Intense symptoms

What does it feel like? (check where appropriate)

<input type="checkbox"/> Numbness	<input type="checkbox"/> Sharp	<input type="checkbox"/> Tingling	<input type="checkbox"/> Shooting
<input type="checkbox"/> Stiffness	<input type="checkbox"/> Burning	<input type="checkbox"/> Dull	<input type="checkbox"/> Throbbing
<input type="checkbox"/> Aching	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Cramping	<input type="checkbox"/> Swelling
<input type="checkbox"/> Nagging	<input type="checkbox"/> Other _____		

## PLEASE CIRCLE AREAS WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

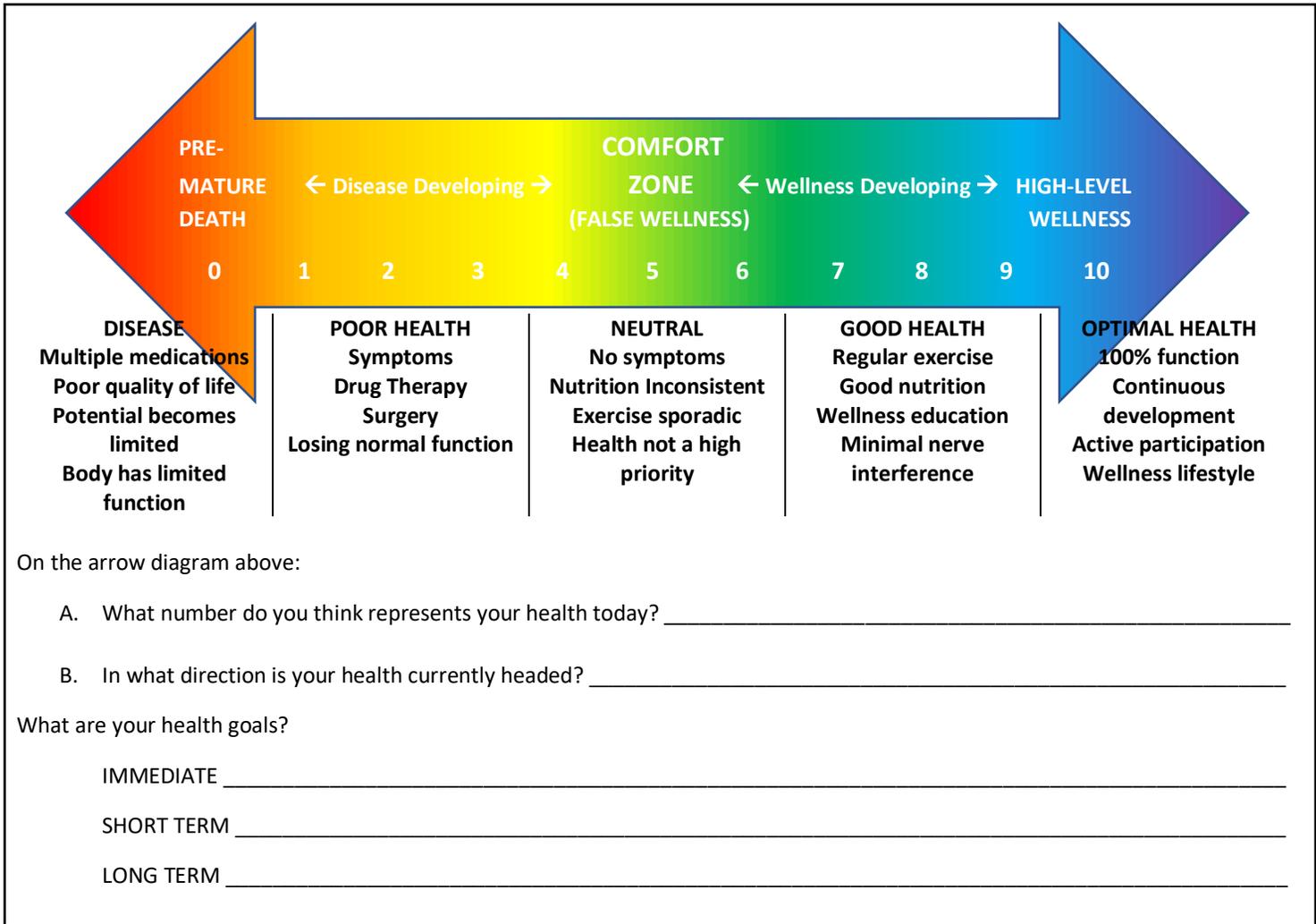


## IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue? ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩  
 Not committed Very committed



# ACTIVE FAMILY WELLNESS

CHIROPRACTIC PHYSICIAN

10721 MAIN STREET, SUITE 1500

FAIRFAX, VA 22030

P: (703) 373-7113 F: (703) 373-7595

## AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office, hereby authorize Active Family Wellness to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of finding during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment, the reason why the above named is considered necessary, the benefits, the risks and side effects of the treatment and consequences of not having the proposed treatment or possible alternative modes (referrals) of treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments which he feels at the time, based upon the facts then know, is in my best interest.

My doctor responded to all of my requests for information about proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to treatment. I also certify that no guarantee of assurance has been made as to the results they may be obtained.

---

Name

Date

---

Signature

---

Parent or Guardian Signature (for minors)

## ACTIVE FAMILY WELLNESS

### DR. GREGORY K. LEE PLLC

10721 Main Street, Suite 1500

Fairfax, VA 22030

Phone #: 703.373.7113 Fax: 703.373.7595

#### Notice of Privacy Practices

Effective September 23, 2013

#### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

The Practice (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

#### **HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

**For Treatment** – We may use your PHI to provide you with treatment. We may disclose your PHI to doctors, nurses, technicians, clinicians, medical students, hospitals and other health facilities involved in or consulting in your care. We may also disclose information about you to people outside the practice, such as other health care providers involved in providing treatment to you, and to people who may be involved in your care, such as family members, clergy, or others we use to provide services that are part of your care. If we refer you to another health care provider, we would, as part of the referral process share PHI information about you. For example, if you were referred to a specialist, we would contact the doctor's office and provide such information about you to them so that they could provide services to you.

**For Payment** – We may use and disclose your PHI so we can be paid for the services we provide to you. For example, we may need to give your insurance company information about the health care services we provided to you so your insurance company will pay us for those services or reimburse you for amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your condition and the health care you need to receive prior approval or to determine whether your plan will cover the services.

**For Health Care Operations** – We may use and disclose your PHI for our own health care operations and the operations of other individuals or organizations involved in providing your care. This is necessary for us to operate and to make sure that our patients receive quality health care. For example, we may use information about you to review the services we provide and the performance of our employees in caring for you.

#### **OTHER USE & DISCLOSURES THAT ARE REQUIRED OR PERMITTED BY LAW**

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

**Appointment Reminders** -We may use and disclose your PHI to remind you by telephone or mail about appointments you have with us, annual exams, or to follow up on missed or cancelled appointments.

**Individuals Involved in Your Care or Payment for Your Care** – We may disclose to a family member, other relative, a close friend, or any other person identified by you. Certain limited PHI that is directly related to that person's involvement with your care or payment for your care. We may use or disclose your PHI to notify those persons of your location or general condition. This includes in the event of your death unless you have specifically instructed us otherwise. If you are unable to specifically agree or object, we may use our best judgment when communicating with your family and others.

**Disaster Relief** - We also may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts. This will be done to coordinate information with those organizations in notifying a family member, other relative, close friend or other individual of your location and general condition.

**De-identified Information** – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

**Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

**Personal Representative** – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

**Emergency Situations** – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

**Public Health and Safety Activities** – The Practice may disclose your PHI about you for public health activities and purposes. This includes reporting information to a public health authority that is authorized by law to collect or receive the information. These activities generally include:

- To prevent or control disease, injury or disability

- To report births or deaths
- To report child, elder, or dependent adult abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Victims of Abuse, Neglect or Domestic Violence** – We may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if we believe an adult or child is a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is (a) required by law, (b) agreed to by you, (c) authorized by law and we believe the disclosure is necessary to prevent serious harm, or, (d) if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

**Health Oversight Activities** – We may disclose your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight agencies to monitor the nation’s health care system, government benefit programs, and for the enforcement of civil rights laws.

**Judicial and Administrative Proceedings** – We may disclose your PHI in response to a court or administrative order. We also may disclose information about you in response to a subpoena, discovery request, or other legal process but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

**Disclosures for Law Enforcement Purposes** – We may disclose your PHI to law enforcement officials for these purposes:

- As required by law
- In response to a court, grand jury or administrative order, warrant or subpoena
- To identify or locate a suspect, fugitive, material witness or missing person
- About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person’s agreement
- To alert a potential victim or victims or intending harm (“duty to warn”)
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct
- About crimes that occur at our facilities
- To report a crime, a victim of a crime or a person who committed a crime in emergency circumstances

**To Avert Serious Threat to Health or Safety** – We will use and disclose your PHI when we have a “duty to report” under state or federal law because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to help prevent a threat.

**Coroners, Medical Examiners and Funeral Directors** – We may disclose your PHI to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death. We also may disclose information to funeral directors so they can carry out their duties.

**Organ, Eye or Tissue Donation** – To facilitate organ, eye or tissue donation and transplantation, we may disclose your PHI to organizations that handle organ procurement, banking or transplantation.

**Workers Compensation** – We may disclose your PHI to the extent necessary to comply with worker’s compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

**Special Government Functions** – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release information about foreign military authority. We may disclose information about you to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

**Research** – We may use and/or disclose your PHI for research projects that are subject to a special review process. If researchers are allowed access to information that identifies who you are, we will ask for your permission.

**Fundraising** – We may contact you with respect to fundraising campaigns. If you do not wish to be contacted for fundraising campaigns, please notify our Privacy Officer in writing.

## **AUTHORIZATION**

The following uses and/or disclosures specifically require your express written permission:

**Marketing Purposes** – We will not use or disclose your PHI for marketing purposes for which we have accepted payment without your express written permission. However, we may contact you with information about products, services or treatment alternatives directly related to your treatment and care.

**Sale of Health Information** – We will not sell your PHI without your written authorization. If you do authorize such a sale, the authorization will disclose that we will receive compensation for the information that you have authorized us to sell. You have the right to revoke the authorization at any time, which will halt any future sale.

Uses and/or disclosures other than those described in this Notice will be made only with your written authorization. If you do authorize a use and/or disclosure, you have the right to revoke that authorization at any time by submitting a revocation in writing to our Privacy Officer. However, revocation cannot be retroactive and will only impact uses and/or disclosures after the date of revocation.

## **YOUR RIGHTS**

**Right to Revoke Authorization** – You have the right to revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice’s Privacy Officer.

**Right to Request Restrictions** – You have the right to request that we restrict the uses or disclosures of your information for treatment, payment or healthcare operations. You may also request that we limit the information we share about you with a relative or friend of yours. You also have the right to restrict disclosure of information to your commercial health insurance plan regarding services or products that you paid for in full, out-of-pocket and we will abide by that request unless we are legally obligated to do so.

We are not required to agree to any other requested restriction. If we agree, we will follow your request unless the information is needed to a) give you emergency treatment, b) report to the Department of Health and Human Services, or c) the disclosure is described in the "Uses and Disclosures That Are Required or Permitted by Law" section. To request a restriction, you must have your request in writing to the Practice's Privacy Officer. You must tell us: a) what information you want to limit, b) whether you want to limit use or disclosure or both and c) to whom you want the limits to apply. Either you or we can terminate restrictions at a later date.

**Right to Receive Confidential Communications** – You have the right to request that we communicate your PHI in a certain way or at a certain place. For example, you can ask that we only contact you by mail or at work.

If you want to request confidential communications you must do so in writing to our Practice's Privacy Officer and explain how or where you can be contacted. You do not need to give us a reason for your request. We will accommodate all reasonable requests.

**Right to Inspect and Copy** – You have the right to inspect and request copies of your information.

To inspect or copy your information, you may either complete an Authorization to Release/Obtain Information form or write a letter of request, stating the type of information to be released, the date(s) of service being requested, the purpose of the request, and whether you wish to review the record or receive copies of the requested information in your preferred format. We will abide by your request in the format you have requested, if we are able to do so. If we cannot provide your records to you in the requested format, we will attempt to provide them in an alternative format that you agree to. You may also request that your records be sent to another person that you have designated in writing. Direct this request to the Practice's Privacy Officer. You may be charged a fee for the cost of copying, mailing or other expenses related with your request.

We may deny your request to inspect and copy information in a few limited situations. If your request is denied, you may ask for our decision to be reviewed. The Practice will choose a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

**Right to Amend** – If you feel that your PHI is incorrect, you have the right to ask us to amend it, for as long as the information is maintained by us. To request an amendment, you must submit your request in writing to the Practice's Privacy Officer. You must provide a reason for the amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason for wanting the amendment. We also may deny your request if the information: a) was not created by us, unless the person or entity that created the information is no longer available to amend the information, b) is not part of the information maintained by the Practice, c) is not information that you would be permitted to inspect and copy or d) is accurate and complete.

If your request is granted the Practice will make the appropriate changes and inform you and others, as needed or required. If we deny your request, we will explain the denial in writing to you and explain any further steps you may wish to take.

**Right to an Accounting of Disclosures** – You have the right to request an accounting of disclosures. This is a list of certain disclosures we have made regarding your PHI. To request an accounting of disclosures, you must write to the Practice's Privacy Officer. Your request must state a time period for the disclosures. The time period may be for up to six years prior to the date on which you request the list, but may not include disclosures made before April 14, 2003.

There is no charge for the first list we provide to you in any 12-month period. For additional lists, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost in advance. You may withdraw or change your request to avoid or reduce the fee.

Certain types of disclosures are not included in such an accounting. These include disclosures made for treatment, payment or healthcare operations; disclosures made to you or for our facility directory; disclosures made with your authorization; disclosures for national security or intelligence purposes or to correctional institutions or law enforcement officials in some circumstances.

**Right to a Paper Copy of this Notice** – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

**Right to File a Complaint** – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

**Name:** Dr. Gregory K Lee

**Address:** 10721 Main Street, Suite 1500 Fairfax, VA 22030

**Telephone No.:** 703-373-7113

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_