TODAY'S DATE _____

PT. NUMBER _____

PATIENT'S DEMOGRAPHICS:

PATIENT'S FIRST NAME _____ LAST NAME _____ **AGE** _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ **SEX:** _____

HOME PHONE _____ CELL OR WORK PHONE _____ **E-MAIL** _____

HOME ADDRESS _____

City _____ State _____ **Zip** _____

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN _____

PARENT/GUARDIAN DOB _____ **PARENT/GUARDIAN SS #** _____

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT NAME _____ RELATION TO PATIENT _____

PRIMARY PHONE # _____ ALTERNATE PHONE # _____

EMPLOYMENT INFORMATION

COMPANY _____ PHONE _____

ADDRESS _____

City _____ State _____ **Zip** _____

INSURANCE INFORMATION:

INSURANCE COMPANY NAME _____

ADDRESS _____

City _____ State _____ **Zip** _____

PHONE _____ EXTENSION _____

MEMBER ID # _____ GROUP # _____

PERSONAL (PRIMARY) PHYSICIAN _____ PHONE _____

ADDRESS _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

REFERRING PHYSICIAN _____ PHONE _____

ADDRESS _____

PHARMACY:NAME _____ ADDRESS _____

PHONE _____ FAX _____

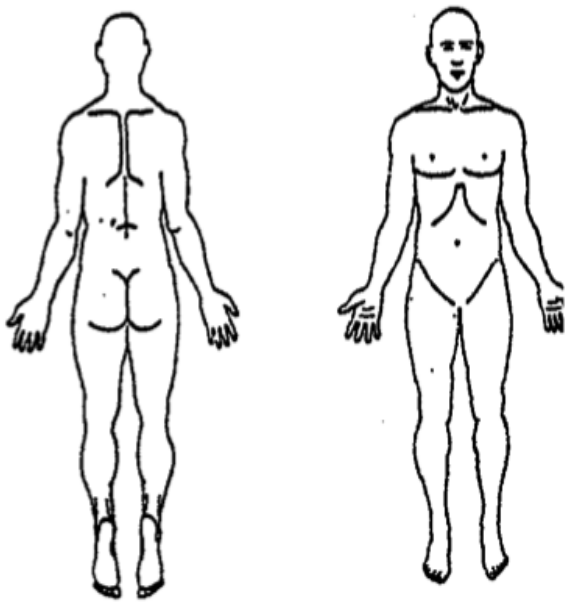
SDSR

HEALTH HISTORY

PATIENT NAME _____ Date _____

WHERE IS YOUR PAIN LOCATED?(Be Specific and Label Worst Area) PATIENT TO DRAW/MARK ALL THAT APPLY

Head	☐ L	☐ R
Neck	☐ L	☐ R
Upper Back	☐ L	☐ R
Mid Back	☐ L	☐ R
Low Back	☐ L	☐ R
Shoulder	☐ L	☐ R
Elbow	☐ L	☐ R
Wrist	☐ L	☐ R
Hand	☐ L	☐ R
Buttock	☐ L	☐ R
Leg (thigh)	☐ L	☐ R
Knee	☐ L	☐ R
Calf	☐ L	☐ R
Foot	☐ L	☐ R



DATE OF INJURY _____

HOW DID YOU GET HURT? **(Please give details including dates and places)**

WHAT BODY PARTS DID YOU HURT?

HAVE YOU EVER HURT THIS BODY PART BEFORE? ☐YES ☐NO HOW: _____

WHO **FIRST** TREATED YOU, AND WHERE? _____

WHO HAS TREATED YOU SINCE?

CHARACTER OF YOUR PAIN PLEASE MARK ALL THAT APPLY & THE LOCATION IT OCCURS:

CONTINUOUS (ALL DAY): ☐DULL ☐SHARP ☐ACHING ☐THROBBING ☐SHOOTING ☐RADIATING ☐BURNING ☐TINGLING ☐NUMB ☐HOT WHERE: _____

INTERMITTENT (ON & OFF) ☐DULL ☐SHARP ☐ACHING ☐THROBBING ☐SHOOTING ☐RADIATING ☐BURNING ☐TINGLING ☐NUMB ☐HOT WHERE: _____

OCCASIONALLY ☐DULL ☐SHARP ☐ACHING ☐THROBBING ☐SHOOTING ☐RADIATING ☐BURNING ☐TINGLING ☐NUMB ☐HOT WHERE: _____

WHAT MAKES YOUR **PAIN WORSE:** ☐Sitting ☐Standing **Bending** ☐Forward ☐Back ☐Walking ☐Lying Flat ☐Driving

How Long Can You Now: Sit _____ min. Stand _____ min. Walk _____ min. Run _____ min.

WHAT MAKES YOUR **PAIN BETTER:** ☐Lying Down ☐Walking ☐Ice ☐Heat ☐PT ☐CHIRO ☐Massage ☐Medications

Other

DOES THE PAIN **LIMITS** YOUR **ACTIVITIES OF DAILY LIVING?** ☐ YES ☐ NO

IF YES, WHAT PERCENT OF THE DAY? ◯10% ◯25% ◯50% ◯75% ◯100%

SDSR

HEALTH HISTORY CONT.

PATIENT NAME _____ Date _____

WHAT CAN YOU **NOT** DO OR HAVE **DIFFICULTY** DOING NOW? (Mark all that apply)

Self Care:	☐Showering	☐Brushing Hair	☐Brushing Teeth	☐Putting on cloths	
Communication:	☐Speaking	☐Writing	☐Typing	☐Talking on Phone	
Physical Activity:	☐Walking stairs	☐Walking	☐Standing	☐Sitting	☐Exercise
Sensory Function:	☐Hearing	☐Seeing	☐Feeling things	☐Tasting	☐Smelling
Hand Activity:	☐Lifting	☐Pulling/Pushing	☐Grasping	☐Turning pages	☐Holding things
Travel:	☐Driving a car	☐Turning head to look	☐Pain with sitting	☐Pain with bumps in the road	

DOES THE PAIN AFFECT YOUR SLEEP? ☐YES ☐NO

IF YES, PLEASE DESCRIBE YOUR SLEEPING HABITS:

DO YOU FEEL DEPRESSED? ☐YES ☐NO **DID YOU FEEL DEPRESSED BEFORE YOUR INJURY?** ☐YES ☐NO

DO YOU HAVE ANY THOUGHTS OF DOING HARM TO YOURSELF OR OTHERS? ☐YES ☐NO

WHAT TREATMENTS HAVE YOU HAD?

	DATES DONE	DID THIS HELP?
PHYSICAL THERAPY	_____	☐YES ☐NO
CHIROPRACTIC THERAPY	_____	☐YES ☐NO
HEAT TREATMENT	_____	☐YES ☐NO
ICE TREATMENT	_____	☐YES ☐NO
ACUPUNCTURE	_____	☐YES ☐NO
EPIDURAL INJECTIONS	_____	☐YES ☐NO
FACET INJECTIONS	_____	☐YES ☐NO
TRIGGER POINT INJECTIONS	_____	☐YES ☐NO
JOINT INJECTIONS	_____	☐YES ☐NO
PSYCHOLOGISTS	_____	☐YES ☐NO

NAME _____ PHONE _____

HAVE YOU HAD ANY RECENT (Mark all that apply) ☐X-RAYS ☐MRI's ☐CT's?

IF SO, WHAT DID THEY SHOW?

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSE	TABLETS PER DAY	PRESCRIBED BY (Dr.)

DO YOU TAKE **BLOOD THINNERS**? ☐YES ☐No (DRUG NAME AND DOSE) _____

ALLERGIES/INTOLERANCE: DO YOU HAVE ANY **ALLERGIES TO MEDICATIONS** ? ☐YES ☐NO

LIST DRUGS AND TYPE OF REACTIONS

PATIENT NAME _____ Date _____

PAST MEDICAL PROBLEMS HISTORY: (Mark all conditions you have or had in the past)

☐HEART ATTACK	☐ASTHMA	☐PROSTATE PROBLEM	☐ARTHRITIS
☐HEART DISEASE	☐DIABETES	☐STOMACH ULCER	☐INTESTINAL PROBLEMS
☐ANGINA (CHEST PAIN)	☐CANCER	☐PREGNANCY	☐C-SECTIONS
☐STROKE	☐LIVER PROBLEMS	☐SEIZURES	☐OTHERS _____
☐HIGH BLOOD PRESSURE	☐TUBERCULOSIS	☐KIDNEY PROBLEMS	
☐DEPRESSION	☐LUNG PROBLEMS	☐BLEEDING PROBLEMS	☐PREVIOUS INJURIES:DATE _____
☐THYROID PROBLEMS	☐ANXIETY	☐SLEEPING DIFFICULTIES	☐WHAT BODY PART? _____

SURGERIES YOU HAVE HAD:

SURGERY	DATE (Most Recent First)	PHYSICIAN	DID IT HELP?

HOSPITALIZATIONS YOU HAVE HAD:

SURGERIES YOU HAVE HAD:

DATE (Most Recent First)	REASON	HOSPITAL (Name and Location)

FAMILY HISTORY: (i.e., Joint/Back Problems, Arthritis, Cancer, Lung Problems, Heart Disease, etc.)

Please List conditions on the lines provided:

Mother:	☐Alive ☐Deceased	_____	_____
Father:	☐Alive ☐Deceased	_____	_____
Children:	☐Alive ☐Deceased	_____	_____
Siblings:	☐Alive ☐Deceased	_____	_____
Uncle:	☐Alive ☐Deceased	_____	_____
Aunt:	☐Alive ☐Deceased	_____	_____
Grandfather:	☐Alive ☐Deceased	_____	_____
Grandmother:	☐Alive ☐Deceased	_____	_____

SOCIAL HISTORY:

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐DIVORCED ☐SEPERATED

CHILDREN: HOW MANY? _____ HOW MANY LIVE WITH YOU? _____

EDUCATION: LAST GRADE COMPLETED: _____

TOBACCO – PACKS/DAY _____ PRESENTLY or _____ years SINCE YOU QUIT

ALCOHOL – DRINKS: ☐Day or ☐Week _____ What? _____

PATIENT NAME _____ Date _____

ACTIVITIES / EXERCISE YOU DID PRIOR TO YOUR INJURY _____

OCCUPATION _____

BRIEFLY DESCRIBE WHAT YOU DO AT WORK:

_____

STREET DRUGS or PAST DRUG DEPENDENCY? ☐YES ☐NO What? _____

ROS - DO YOU HAVE ANY OF THE FOLLOWING? (Mark all that apply)

☐CHEST PAIN OR PRESSURE	☐EASY BRUISING	☐RECENT BLEEDING	☐PROBLEMS WITH URINATION
☐SHORTNESS OF BREATH	☐ABDOMINAL PAIN	☐CONSTIPATION	☐INTOLERANT TO COLD/HEAT
☐COUGH	☐DIZZINESS	☐DIARRHEA	☐NAUSEA
☐ANKLE SWELLING	☐FAINTING	☐VISION CHANGES	☐WEAKNESS

☐OTHER _____

INITIAL VITAL SIGNS:

Height _____ Weight _____

PAIN LEVEL AT ITS BEST (when at rest) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

PAIN LEVEL AT ITS WORST (when active) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

MILD MODERATE SEVERE

TO OUR PATIENTS:

I HEREBY AUTHORIZE AND ASSIGN TO SAN DIEGO SPINE & REHAB / DIRECT HEALTH MEDICAL CENTER AND THEIR DOCTORS MY RIGHTS TO RECEIVE PAYMENTS FROM NEGLIGENT PARTIES OR FROM INSURANCE COMPANIES. I AUTHORIZE SAN DIEGO SPINE & REHAB / DIRECT HEALTH MEDICAL CENTER TO RELEASE ANY INFORMATION TO ANY INSURANCE CARRIER, ADJUSTER, ATTORNEY, OR GOVERNMENT AGENCY THAT WILL ASSIST IN THE PAYMENT FOR SERVICES RENDERED BY SAN DIEGO SPINE & REHAB / DIRECT HEALTH MEDICAL CENTER AND ITS DOCTORS.

TO OUR PATIENTS:

PATIENT SIGNATURE _____ Date _____

MULTIPLE REGION FUNCTIONAL CAPACITY

PATIENT NAME _____ Date _____ age _____

Patient: Fill out sections 1 to 10. In each category, check one box that best applies your current condition

1. CURRENT PAIN INTESNITY

☐	I have no pain currently
☐	I have occasionally pain which mildly disturbs me at work and home.
☐	I have frequent annoying pain with an occasional pain that slow me down
☐	I have frequent moderate level pain and occasional severe pain that stop me from performing more strenuous activities.
☐	I have some degree of pain at all times, with frequent bouts of severe pain which prevent my performing many normal activities
☐	I have pain all of the time, mostly severe, which I am unable to do most activities for myself. Medications don't help.

2. WORK ABILITY

☐	I am able to currently work full time with no pain.
☐	I work full time and have slight (annoying) symptoms which occasionally may slow me down thus taking slightly longer.
☐	I work full time. My work output quality and/or quantity are reduced 10-20%. Symptoms vary from a slight to moderate levels which cause intermittent halting. I require assistance occasionally at work.
☐	I am able to work part time. I am not able to work at normal pace beyond two hours and at slower pace beyond four hours. My performance output quality and/or quantity are reduced 30 to 60%.
☐	I am able to work part time. I am not able to work at normal pace for more than 30-60 minutes at a time. I can work at a slower pace beyond two hours. My ability to perform in output are reduced by over 70%.
☐	I am not able to work at normal or slower pace at all. Job quality and/or quantity are reduced more than 90%. Unable to work on part-time status even with a flexible work schedule.

3. SPORTS, HOBBIES, AND SOCIAL ACTIVITIES

☐	I can perform normal sports, hobby activities, and social activities with my friends, family, or business acquaintances.
☐	My sports, hobby, and social life are normal but pain slows me down occasionally.
☐	Pain or other symptoms limits my more energetic or competitive sports, hobby activities, social activities such as dancing and running.
☐	Severe pain or other symptoms limits moderate energetic sports, hobby, and social activity. I do not go out as often.
☐	Pain or other symptoms limits me to only minimal sports, hobby, and social activity. I usually stay at home.
☐	Unable to participate in any sports, hobby, or social activity due to pain.

4. HOME ACTIVITIES

☐	I can perform normal home activities such as vacuuming, cooking, cleaning, mowing lawn, doing laundry with no pain.
☐	I am able to do all normal home duties but pain slows me down occasionally with very strenuous activities.
☐	Pain prohibits very strenuous home activities. I am able to do lighter to moderate strenuous level home activities.
☐	Severe pain or other symptoms limits moderate and strenuous home activities. I need help doing some activities.
☐	I am able to do only light home activities. I am unable to vacuum floor, do dishes, sweep, mop, and laundry.
☐	I am unable to do any home activities due to pain or other symptoms. I need help putting on clothes and taking bath.

5. SLEEPING

☐	I normally have no difficulty sleeping due to pain or other symptoms.
☐	I have occasional difficulty sleeping due to pain or other symptoms waking up at night resulting in 30 minutes loss of sleep.
☐	I have occasional difficulty sleeping due to pain or other symptoms. I loose 10-15% of normal sleeping hours a night.
☐	I have occasional difficulty sleeping due to pain or other symptoms. I am restless most of the night. I lose 25% of hours of sleep a night.
☐	My sleeping hours are reduced about 50%. I usually need medications to sleep well.
☐	I have no normal sleeping hours. I am never able to sleep more than 2-3 hours without heavy medication. I never feel rested.

6. SITTING

☐	I can sit at my desk or drive my car normally with no pain.
☐	I can sit at my desk or drive my car with occasional annoying pain. I need to take breaks on long trips.
☐	Sitting or driving causes frequent annoying pain. Pain becomes severe if sitting for more than 2 hours where I need to change position.
☐	I can sit or drive for 3-4 hours but I need frequent breaks to change my body position. Unable to sit constantly over 1 hour.
☐	I cannot sit or drive for more than 30 minutes at a time due to pain severity.
☐	I cannot sit at my desk, chair at home, or drive my car at any time due to pain severity.

7. UPPER BODY FUNCTION (Neck and arms)

☐	I am able to use my neck, shoulders, arms and hands in all normal activities with no pain.
☐	I am able to use my neck, shoulders, arms and hands in all normal activities with occasional annoying pain.
☐	I am able to lift and move my head and neck, lift arms over my head, reach over my head, carry objects, grip objects with my hand. I have occasional pain when lifting heavy objects over my head which cause me to stop. Occasionally will have difficulty feeling or gripping objects with my hands due to either weakness or numbness. I am limited to light to moderate weights in my hands.
☐	I am able to lift my arms up to the height of my shoulder for short periods of time but not over my head, carry light to moderate weight objects, grip objects with my hands. I get occasional pain when lifting heavy objects over my head. Occasionally will have difficulty typing, feeling, or gripping objects with my hands due to weakness or numbness. I drop objects 2-3 times a week. I have to use 2 hands for some activities where I could it with one hand before. I am limited to moderate weights.
☐	I am able carry and grip light objects only. I get frequent pain when lifting any objects over my waist and sometimes am unable to lift to the height of my shoulder. I am unable to lift my arms to the height of my shoulder and lift over my head. I frequently have difficulty feeling or gripping objects with my hands due to either weakness or numbness. I drop objects daily unless I am very careful. I have to use two hands for most activities where I could it with one hand before. I have frequent difficulty typing, using the computer, and writing letters. I am limited to light weights. I have lost 75% of hand lifting ability.
☐	I am able to lift my arms to the level of my shoulders only and just lifting my arms above my waist causes severe pain. I am unable to lift any object over the height of my waist. Every time I lift my arms up I get severe pain in my neck, shoulders, or arm and I have to lower my arm or arms immediately. I am unable to write letters. I am unable to lift 5 pounds in my hands.

8. LOWER BODY FUNCTION (Low back and legs)

☐	I can sit, drive, stand, squat, stoop, walk, bend my knees, use my feet, and lift normal heavy weights with no low back/leg pain.
☐	I can sit, drive, stand, squat, stoop, walk, bend my knees, use my feet, and lift normal heavy weights with occasional annoyance of mild pain. I can do all of these activities but slower if demands are high.
☐	Moderate levels of low back/leg pain happen if I do prolonged or repeated sitting, driving, standing, stooping, walking, or bending. I can lift heavy objects of positioned properly. Pain limits me to walking ½ mile. Unable to stand for more than 45 minutes at a time. Repeated stooping or bending more than 20 minutes cause me to slow down.
☐	Moderate to severe levels of low back/leg pain happen if I do prolonged or repeated sitting, driving, standing, stooping, walking, or bending. I can't lift heavy objects at all and am able to lift moderately heavy objects (1/4 my body weight) if properly positioned. Pain limits me to walking ¼ mile. Unable to stand for more than 30 minutes at a time.
☐	I experiences severe levels of pain if I do short term sitting, driving, standing, stopping, walking or bending. I can't lift moderate or heavy objects at all and am able to lift light objects only (10-15lbs). Need lumber belt support and/or cane for support to walk. Pain limits me to walking to one block. Unable to stand for more than 10 minutes at a time.
☐	I experience severe levels of pain if I do sitting, driving, standing, stopping, walking or bending. I am able to walk only with use of cane, crutches or wheelchair. I need to lie down frequently to relieve pain. I am unable to lift or carry any object over five pounds. I need lumbar belt support and/or cane for support to move about in my home. During the daytime I lie down 3-4 hours.

9. HEADACHES

☐	I have no headaches normally
☐	I have headaches occasionally which only annoy me at work or at home.
☐	I have occasional headaches which are intense enough to slow me down at work and home occasionally.
☐	I have occasional headaches which causes me to stop and rest for short periods of time frequently
☐	I have frequent headaches which stops all of my activity. I frequently lose time at work or have delays in work production due to pain.
☐	I have frequent headaches which cause me not being able to go to work, school, home, or participate in recreational activities.

10. MENTAL ABILITY

☐	My memory and mental function are normal. I have no difficulty with work or home demands.
☐	I am able to perform most mental activities and am able to function at work, home, and in society. I have occasional slight difficulty with complex tasks, memory, and math.
☐	I am able to functions normally in most work, home, and society activities. Complex tasks, multiple tasks, and intense concentration tasks are difficult, often resulting in mistakes. I have noticed about a 10-25% memory loss and job performance decline recently.
☐	I am not able to handle difficult or complex tasks. I have notable memory loss and difficulty making decisions. My friends, family, and I have noticed recent personality changes., It takes much linger to do work and home tasks. I can handle one simple task at a time. I have to write down my daily tasks to remember. My job performance ratings are poor. I have noticed about 26-50% memory loss and job performance decline recently.
☐	I am able to handle only simple tasks one at a time. Unable to keep full time job. My job performance ratings are poor. My reaction times have slowed down a lot. I have notice about a 52-75% memory loss and job performance declined recently.
☐	I am unable to hold any job at all. I am unable to balance my checkbook and need help. I am unable to shop without a shopping list. I have severe performance difficulties. I am unable to remember instructions.

TOTAL SCORE (1-10) _____ x2= _____

Recommendations: _____

Reviewed By _____ MD PA Date Reviewed: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

San Diego Spine and Rehab, Inc.

San Diego Spine and Rehab Inc.- OCEANSIDE

3772 Mission Ave Suite 122

Oceanside, CA 92058

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below: _

Date:		Initials:		Reason:	

San Diego Spine & Rehab Inc. - OCEANSIDE
Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Location: