Choices Integrative Healthcare of Sedona
95 Soldier Pass Rd, Suite B
Sedona, AZ 86336
Telephone - 928-203-4844
Fax - 928-203-4497

Dear CDL Client

Thank you for choosing CHOICES for your CDL medical examination. Our Family Nurse Practitioner, Karen M. Johnson is certified to do this examination on your behalf.

In order to schedule your CDL appointment, please return the attached paperwork to our office. If you are faxing or mailing your documents to us, we will call you the day it has been received to schedule your CDL examination. Our fax number and address appear above.

The fee for the examination is $105 which includes the dip urinalysis. The fee is due at the time of service. If your employer is paying for your examination, you may bring a check payable to Choices in the amount of $105.00

Thank you again for your confidence in Choices Integrative Healthcare of Sedona.

Best regards,
Devin A. Mikles, M.D.(H), FACP
Medical Director

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CDL ONLY
PATIENT INFORMATION

Name (Last) _____ First _____ MI _____

Mailing Address _____

City _____ State _____ Zip _____

Home Telephone ( ) _____ Cell ( )_____

E Mail Address _____

Date of Birth _____ Social Security Number _____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Telephone ( ) _____

Relationship (Spouse/Parent ect..)_____

EMPLOYER INFORMATION:

Business Name: _____ Work phone ( ) _____

Acknowledgement of Receipt of Privacy Notice

Patient Name:_____

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship to Patient (parent, legal guardian, personal Representative ect..)

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Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Choices Integrative Healthcare of Sedona appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees at day and time of service.
I have read the above policy regarding my financial responsibility to Choices Integrative Healthcare of Sedona, for providing healthcare services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate

Patient/Guarantor
Signature_____Date_____

Consent for Treatment and Authorization to Release Information

I hereby authorize Choices Integrative Healthcare of Sedona, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.
I further authorize Choices Integrative Healthcare of Sedona, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Non-Sufficient Funds

I understand that if for any reason a check or credit card payment is denied or returned to Choices Integrative Healthcare of Sedona, I will be responsible to pay a $35 fee.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.
I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. I understand there is also a $25 charge per no show or late cancellation that will be billed to me by the practice.
Choices Integrative Healthcare of Sedona will notify you in writing, via certified mail, if you are discharged from care.

Patient/Guarantor Signature _____ Date _____

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Joint 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. Please review it carefully.
If you have any questions about this notice please contact our privacy contact who is: Angie Olson, Office Manager**.**

This "Joint Notice of Privacy Practices" describes how we may use or disclose your protected health information (medical records) 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 the Joint Notice of Privacy Practices. [We may change the terms of our notice at any time.] Any modification 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 by accessing our website (www.choiceshealthcare.com) or asking for one at the time of your next visit to the office.

We must make a good faith effort to obtain your written acknowledgement that you have received our Joint Notice of Privacy Practices. If you refuse to acknowledge receiving the notice we must know why. This information must be documented in your protected health information.

You should also know that we are happy to take this opportunity to share our feelings about the responsibility we feel toward you and the private information you have entrusted to us. While your original medical chart belongs to the clinic, you have a right to know what is in it. You may request and receive information you request from your personal protected health information. The clinic requires twenty-four (24) hours notice to fulfill such a request.

This **Joint Notice of Privacy Practices** covers all health care providers at Choices Integrative Healthcare of Sedona which is considered an "organized health care arrangement." Choices Integrative Healthcare providers may be physicians, nurse practitioners, physical therapists, mental health counselors, chiropractors, acupuncturists, manual therapists and other therapists who provide alternative and traditional health services.

I. USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

The primary use for your medical record remains to help your health care provider keep track of your health history including all the symptoms that have brought you to the clinic, your family health history, examination and test results, diagnoses made, treatments supplied and recommended and medications given. All health care providers at Choices Integrative Healthcare of Sedona may share your medical information with one another to carry out treatment, payment or health care operations.
We are permitted by law to use your protected health information for 'treatment, payment and health care operations without your consent. What does this mean? It means that the information in your medical record may be used and disclosed by Choices Integrative Healthcare providers, our office staff and others outside of our office that are involved in your care for the purpose of providing health care services to you. The following examples are intended to inform you of some of the ways we might use your medical record without your consent. ***This listing of examples is not intended to be exhaustive.***

TREATMENT

- They might be sent to another doctor or therapist who you or we are asking to take part in your care.
- They might be sent to a home health agency that provides care for you.
- Information might be sent to a laboratory or other testing facility.
- They might be used in a practitioner team meeting in order to evaluate and facilitate the coordination of your care.

PAYMENT

- Our billing personnel might review a progress note in order to accurately bill your insurance company.
- We might send a copy of a course of treatment to an insurer who requests written support for a bill we have sent them for your care.
- Your insurance may review your records for benefit or medical necessity determination, or utilization review activities.

HEALTH CARE OPERATIONS

- We might use them as part of our quality assessment program in which we review the care our patients receive to be sure we are documenting well and that each provider is rendering medically appropriate care.
- They might be used in activities related to training a medical or physical therapy student.
- We may use a sign-in sheet at the registration desk and we may call your name when a provider is ready to see you.
- We may contact you to remind you of an appointment.
- Your records might be seen by business associates whom we hire to do such things as help us store our records electronically, devise better record systems or perform other jobs related to the efficient operation of our clinic.

To protect your privacy in these cases, we require all of these parties to demonstrate that they comply with our confidentiality requirements and to sign an agreement that limits what they can do with the records.

Other uses and disclosures of your medical records will be made only with your written authorization unless required or permitted by law. You may revoke this authorization, at any time, except to the extent that your provider or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.
We may use and disclose your records in the following instances. You have the opportunity to agree or object to the use of all or part of your records. If you are not present or able to agree or object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

OTHERS INVOLVED IN YOUR CARE: We may disclose to a member of your family, a relative, a close friend or any other person you identify, information that relates directly to that person's involvement in your health care. We may use or disclose 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 of disclose your 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.

EMERGENCIES We may use or disclose your information in an emergency treatment situation.

COMMUNICATION BARRIERS We may use or disclose your information if your provider attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to consent to use and disclosure under the circumstances.

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

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, as 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. The disclosure will be made for the purpose of 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 about abuse or neglect. In addition, if we believe you have been a victim of abuse, neglect or domestic violence we disclose your protected health information 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.

FDA: We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, 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 tribunal judicial or administrative proceeding, in response to an order of the court or administrative tribunal (to the extent that such disclosure is expressly authorized), in certain conditions 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.

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 to perform other duties authorized by law. We may also disclose such information to a funeral director in order for him/her to carry out their duties. We may also disclose such information in reasonable anticipation of death for cadaver organ, eye or tissue donation purposes.

Research: We may also 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 such information.

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, or to authorized federal officials for conducting national security or intelligence activities.

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

Required Uses and Disclosures: Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500 et. Seq.

II. 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 your medical, billing and other records that are contained in a designated record set for as long as we maintain the information. This information is used by the practice for making decisions about you.

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 information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be review able. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Contact 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 healthcare operation. You may also request that any part of such information not be disclosed to family members of 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 healthcare provider is not required to agree to a restriction that you request. If the healthcare provider believes it is in your best interest to permit disclosure of your protected health information, it will not be restricted. If you provider does agree to the requested restriction, we may not use or disclose the 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 provider. You may request a restriction by completing the final section of this agreement. It will then be reviewed and attached to your medical record.

You have the right to receive confidential communication 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 Contact.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of your protected health information about you as a designated record set for as 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 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 healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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.

III. 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 against us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Angela Olson (928) 203-4844 or aolson@choiceshealthcare.com for further information about the complaint process. This notice was published and becomes effective on April 14, 2003.

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