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 **HD PHYSICAL THERAPY INTAKE PAPERWORK**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
                       Last                                                                       First                                                         Middle

DATE OF BIRTH: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_               SEX:  M / F          SOCIAL SECURITY#\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
                       Street                                            City                                                           State                   Zip

PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
                      Name                                                Street                                 City                            State          Zip

EMERGENCY CONTACT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN (If Different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF NEXT DOCTOR FOLLOW UP FOR THIS INJURY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT HDPT? (CIRCLE): **FRIEND/FAMILY   DOCTOR   WEBSITE   MAILING  ATTORNEY   OTHER**

IF "OTHER", PLEASE DESCRIBE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WOULD YOU LIKE TO RECEIVE INFORMATION REGARDING YOUR APPOINTMENTS, BILLING, AND HEALTH UPDATES VIA EMAIL (CIRCLE): Y / N

WOULD YOU LIKE TO BE TEXT MESSAGED APPOINTMENT REMINDERS (CIRCLE): Y / N (Provider):\_\_\_\_\_\_\_\_\_

**PATIENT/GUARDIAN SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **HD PHYSICAL THERAPY INSURANCE INFORMATION**

**PRIMARY HEALTH INSURANCE:** (SKIP **ONLY** IF WORKER'S COMPENSATION CLAIM)

HEALTH INSURANCE CARRIER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY/ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATION: \_\_\_\_\_\_\_\_\_\_\_

**SECONDARY HEALTH INSURANCE (If applicable):**

HEALTH INSURANCE CARRIER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY/ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SUBSCRIBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATION: \_\_\_\_\_\_\_\_\_\_\_

**AUTO INSURANCE:**

**(List YOUR automotive insurance carrier, regardless of fault, if injury is due to a motor vehicle accident)**

INSURANCE CARRIER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CLAIM #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_

ADJUSTER’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INJURY DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORKER’S COMPENSATION:**

INSURANCE CARRIER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CLAIM #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADJUSTER’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INJURY DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTORNEY INFORMATION (If obtained for injury you are seeking treatment for):**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT/GUARDIAN SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **HDPT MEDICAL HISTORY FORM**

 **Do you now have, or have EVER had the following? Please put an X next to all that apply:**

|  |  |  |  |
| --- | --- | --- | --- |
| Latex Allergy                   (   ) | Cardiac Disorders           (   ) | AIDS / HIV                     (     ) | Mental Illness             (      ) |
| Arthritis OA / RA             (   ) | Pacemaker                    (   ) | Hepatitis A B C              (     )  | Asthma                       (      ) |
| Cancer / Tumors            (   ) | Stroke                           (   ) | Seizures / Epilepsy        (     )  | Fracture                      (      ) |
| Diabetes                        (   ) | High/Low Blood Pressure (   ) | Bowel/Bladder Disorder (     ) | Artificial Joint              (      ) |
| Sudden Weight Loss     (    )  | Alcohol/Drug Abuse      (   )  | Osteoporosis                  (     )  | Other:                         (      )  |

**PAST MEDICAL HISTORY:**
Please list previous surgical procedures and provide the date for each:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other significant ailments or problems that have required medical treatment in the past:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received **PHYSICAL THERAPY** for this or any other injury over the last **12 Months**?   Y  /  N

**Females:** Are you currently, or is there a possibility that you may be pregnant?   Y  /  N

**Patient/Guardian Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **HDPT PAIN ASSESSMENT**

 Please Mark the Areas of Pain You are Experiencing on the Diagrams Below:



 **Please Mark the Level of Pain You are Experiencing On The Number Line Below**

 **“0” Represents No Pain / “10” Represents Severe Pain**

Pain at it's **BEST**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
                              0 1            2            3            4            5            6            7            8            9            10

Pain at it’s **WORST**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 0 1 2 3 4 5 6 7 8 9 10

**Patient/Guardian Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **HDPT AUTHORIZATION AND POLICY**

**CONSENT FOR TREATMENT:**
I, the undersigned, voluntarily give consent to HD Physical Therapy, LLC, to perform physical therapy evaluations, assessments, and treatments for the injury(s) I was referred to this facility for or referred myself for. I further understand that no guarantee or promise has been made to me concerning the results of treatment received.

**ASSIGNMENT OF BENEFITS:**
I, the undersigned, authorize direct payment by my insurance company and/or my attorney if out of settlement, for all physical therapy services rendered to HD Physical Therapy, LLC.

F**INANCIAL POLICY:**
I, the undersigned, understand that although HD Physical Therapy will verify my insurance benefits as a courtesy, it is my responsibility to know and understand my own insurance benefits. I understand that I am responsible for paying HD Physical Therapy directly for any applicable deductible, co-insurance, and/or co-payment required by **MY OWN** health insurance policy. This is a mandatory requirement when receiving healthcare services. Failure to meet your financial obligations is a violation of the agreement between you and your health insurance carrier. Please note that the carrier may take additional action when financial obligations are not met. **HD Physical Therapy requires payment at time of service.**

**ACKNOWLEDGEMENT AND UNDERSTANDING:**
It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition or certain physical therapy treatment options be such that it is not covered by my health insurance policy, or if, for any reason, the insurance carrier and/or my attorney refused to pay my balance to this office.

**AUTHORIZATION TO RELEASE INFORMATION:**.
I, the undersigned, authorize HD Physical Therapy to release any information pertinent to my case to any insurance company or attorney to facilitate collections on my balance at this office.

**PATIENT REQUEST FOR RECORDS:**
I, the undersigned, authorize the release of all medical, hospital, or surgical records **pertinent to my case** for the purpose of assisting with physical therapy diagnosis, treatment options and improving the overall quality of care received at HD Physical Therapy, including but not limited to, exams, special tests, OR reports, X-rays, MRI's, CT scans or lab results to this office.

**CANCELLATION / NO-SHOW POLICY:**
We at HD Physical Therapy work hard at providing you with the best care possible so that you reach your health and recovery goals. Your commitment to your physical therapy program is critical to your success and ability to reach these goals. HD Physical Therapy expects that you keep each scheduled appointment.  If you do have to cancel an appointment, we require a courtesy of a **12 hour notice** and ask that you reschedule your cancelled appointment within the same week in order to maintain the prescribed plan of care set by your therapist.  **HD Physical Therapy reserves the right to charge you, NOT your insurance carrier, a fee of $50.00 for any appointment cancelled with a less than 12 hour notice or if NO call is made and you "no-show" for an appointment.  This fee is due at the time of your next scheduled appointment.**We understand that emergencies do happen and thus you **will NOT be charged** for the first offense to the above stated policy.  HD Physical Therapy reserves the right to close your case and discharge you from our care if **3** or more appointments are missed.  **We want to help those patients who have a true desire to improve their health.**

**By signing below, I certify that I have read, fully understand and agree to all policies stated above.**

**Patient/Guardian Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. **PLEASE READ IT CAREFULLY**

As Required by the Privacy Regulations Created as Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HD Physical Therapy (HDPT) must maintain the privacy of your health information that is protected by the rule, and must provide you with notice of our legal duties and privacy practices with respect to our protected health care information.

USES AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION [45 CFR 164.506]

***Treatment:***
Generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

*For example:*
While undergoing physical therapy evaluations and treatments, medical information will be obtained by the therapist and will be recorded in your patient record.  These records may be shared with your health care team so that they know how you are responding to treatment and may be shared with other providers participating in your care to assist them in treating your if referred to them for additional services.

***Payment:***
Encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care.

*For example:*
A bill, which may contain information which identifies you, treatments provided, and your diagnosis, may be submitted to you or a third-party payer such as your health insurer.  We may contact your health insurance carrier in order to determine eligibility.  We may also disclose health information to the extent authorized and to the extent necessary to comply with workers compensation or other similar programs established by law.

***Heath Care Operations:***
Refer to certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities which are limited to the activities listed in the definition of "health care operations at 45 CFR 164.501.

*For example:*
Conducting quality assessment and improvement activities, conducting activities relating to improving health or reducing health care cost, arranging for medical, legal, and auditing services, including fraud and abuse detection and compliance programs, underwriting and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits.

USES AND DISCLOSURE FOR OTHER PURPOSES

***Business Associates:***
We may disclose protected health information to our business associates and allow them to create and receive protected health information on our behalf.

*For example:*
We may share information with a durable medical equipment provider to acquire the appropriate prescribed piece of equipment.

***Notification:***
We may disclose information to notify or assist in notifying a family member, a person responsible for your care, regarding your location or general condition.

***Law Enforcement Purposes:***
When required by federal, state, or local law, we may disclose protected health information in response to a court order subpoena.

***Public Health:***
As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

PATIENT PRIVACY RIGHTS

Below is a list of your privacy rights.  If you chose to request (in writing) how your private health information is used or disclosed, understand that HDPT is not required to agree to your requested restrictions.  However, if agreed to, HDPT is bound to abide by such restrictions [45 CFR 164.522(a)].  Privacy rights are as follows:

* You have the right to request that we further restrict use and disclosure of your protected health information.
* You have the right to request that we communicate your health information to you by certain means or  at a certain location, for example you might request that we may only contact you at work.
* You have the right to obtain, upon request, an accounting of certain disclosures of your protected health information by us.
* You have the right to inspect and obtain a copy of your protected health information.
* You have the right to receive a paper copy of our Notice of Privacy Practices.
* You have the right to revoke this consent (in writing) at any time, except to the extent that action has already been taken.

OUR DUTIES

We are required by law to maintain the privacy of your health information and are also required to provide you with this notice of your legal duties and our privacy practices with respect to your health information.  We must abide by the terms of this notice while it is in effect.

We reserve the right to reserve the right to change the terms of our privacy notices.  If we make a change to our privacy notice, we will notify you in writing when you arrive for your next treatment.

If you believe we have violated your privacy rights, you can file a complaint with the secretary of Health and Human Services.  We will not retaliate against you for filing a complaint.

LEGAL EFFECT OF THIS NOTICE

This notice is not intended to create a contractual or other rights independent of those created in the federal privacy rule.

EFFECTIVE DATE:  May 1st, 2012

**I have read and understand this notice and acknowledge that I was offered a written copy:**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_