Pineapple Health
PATIENT INFORMATION

Name:
☐ Yes, I am going to read Pineapple Health's Office Policies.
Social Security Number (SSN): Date of Birth:

Home Address:

City: State: Zip:

Mailing Address (if different from above):

City: State: Zip:

Daytime Phone: Evening Phone:

Email Address:

Sex: ☐ Male ☐ Female
Marital Spouse: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name: Healthcare Proxy: ☐ Yes ☐ No

Referring Physician's Name & Address:

City: State: Zip:

EMPLOYMENT INFORMATION

Employed: ☐ Yes ☐ No Occupation:

Employer (Parent's employer if minor):

Employer's Address:

City: State: Zip:

Spouse's Employer:

Spouse's Employer's Address:

City: State: Zip:

Phone: Spouse's SSN:

RESPONSIBLE PARTY INFORMATION

Person Responsible for Medical Expenses:

Relationship to Patient: Phone:

Spouse's Employer's Address:

City: State: Zip:

PRIMARY INSURANCE INFORMATION

Insurance Company:

Policy Number:

Medicare Number:

Medicaid Number:

Subscriber's name:

Subscriber's Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address of Insurance Company:

City: State: Zip:

SECONDARY INSURANCE INFORMATION

Insurance Company:

Policy Number:

Medicare Number:

Medicaid Number:

Subscriber's name:

Subscriber's Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address of Insurance Company:

City: State: Zip:

We accept most insurance. However, participation may vary by plan and insurance company so please check with your insurance plan administrator. With regard to the Affordable Care Act (Obamacare), it is your responsibility to contact your insurance company before your appointment to make sure we accept your specific plan.

EMERGENCY INFORMATION

Person to Contact in Case of Emergency, Other than Spouse:

Relationship to Patient: Phone:

Address:

City: State: Zip:

AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

Patient's Signature: _____ Date:

Spouse's Signature: _____ Date:

GENERAL CONSENT FOR MEDICAL TREATMENT

I understand that I have the right to make informed decisions about my health care treatment. I understand that Foothills Family Medicine-Rejenesis specializes in Integrative and Preventive Medicine. I further understand that Dr. Kevin Chan is a recognized specialist in this area. I agree to have Dr. Kevin Chan and his providers and staff do tests and treatments they believe are needed for my care, including my annual physical. These may include but not limited to vital signs, ekgs, spirometries, x-rays, scans, expanded lab tests, allergy testing, lifestyle modifications, physical therapies, acupuncture, medications, hormone replacement therapies, as well as nutritional and herbal supplementations. I know other treatments or tests that may have more risks will be explained to me so I can give informed consent for them if I need them.

Name: Date:

Witness (Optional):

Health Questionnaire

Name: Date: Date of birth:

Chief Complaint:

Brief History of Problem:

Surgical History:

Past Medical History: (Please check if applicable)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Glaucoma
- ☐ Cancer
- ☐ Anemia
- ☐ Liver disease
- ☐ Blood Clots
- ☐ Epilepsy
- ☐ Gastrointestinal
- ☐ Gynecological Problems

Other:

Habits: Alcohol #drinks/week Cigarettes: #cig/day #years year quit

Other tobacco usage: Current frequency:

Caffeine #cups/day Recreational Drugs

Women only: Date of last PAP test Normal? ☐ Abnormal? ☐

Date of last mammogram Normal? ☐ Abnormal? ☐

Date of last period (1st day) Menopausal symptoms?

Irregular periods? ☐ Menstrual pain?

Pre-menstrual complaints?:

History of pregnancies:

Family History:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Glaucoma
- ☐ Cancer
- ☐ Anemia
- ☐ Liver disease
- ☐ Blood Clots
- ☐ Epilepsy
- ☐ Osteoporosis

Other:

Allergies:

Current Medications:

Medication	Dosage	Action

Review of Current/Recent Symptoms: (check all those that are applicable)

General: ☐ Fever ☐ Chills ☐ Weight Loss ☐ Weakness

Skin: ☐ Rash ☐ Itching

Hematopoietic: ☐ Bruising ☐ Bleeding ☐ Anemia

HEENT: ☐ Vision change ☐ Double vision ☐ Glaucoma ☐ Hearing problems
☐ Vertigo

Respiratory: ☐ Cough ☐ Coughing Blood ☐ Shortness of Breath
☐ Infections

Cardiovascular: ☐ Chest Pain ☐ Murmurs ☐ Pain in legs with walking
☐ Swelling in the legs

Gastro-Intestinal ☐ Constipation ☐ Diarrhea ☐ Bleeding ☐ Hemorrhoids
☐ Indigestion ☐ Hepatitis

Genito-Urinary ☐ Burning ☐ Bleeding Leaking (incontinence) ☐ Flank pain
☐ Loss of erections

Muscle-skeletal: ☐ Joint pain ☐ Weakness ☐ Back pain ☐ Cramps

Neurologic: ☐ Headache ☐ Dizziness ☐ Seizures ☐ Blackouts
☐ Depression ☐ Sleeping problems

Other:

Other Comments:

_____ _____

Signature Date

Authorization to Disclose Health Information

I, the undersigned, authorize:

Pineapple Health/Rejenesis
12010 S. Warner-Elliot Loop
Phoenix, AZ 85044
Phone: 480-961-2366 Fax: 480-961-2367

Patient Information:

Patient Full Name: _____ Other Names During Treatment? _____

Patient Address:_____ Date of Birth: _____

City: _____ State: _____ Zip:_____ Phone Number: _____

Release Information To or From (circle):

-This box must be complete in order for the request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip:_____ Fax Number: _____

Purpose of Request: ☐Personal ☐Treatment ☐Legal ☐Insurance ☐Disability
☐Transfer/Reason _____ ☐Other_____

Information to be Released:

Section 1:

For personal requests, there will be a $15 flat fee and $0.25 per page fee for all requests on paper(plus the cost of postage and envelope) or there will be a $10 flat fee and a $0.25 per page fee for all requests on CD (plus the cost of postage and envelope). Please be specific in the information you would like in Section 2:

For doctor to doctor requests, there will be no fee. By default, the past two years of pertinent information will be sent. Please provide any specific additional information in Section 2:

Section 2:

Please provide information in my medical record for dates:

From_____To_____

- ☐ History and Physical Examination
- ☐ Office Visit Note
- ☐ Laboratory Tests
- ☐ X-Rays/Imaging Reports
- ☐ Other_____

Form of Records:

Please Choose:

☐Records on Paper

☐Records on CD ----------> 4 Digit Encryption Key: _____

*If no encryption key is provided, encryption key will be included with CD upon delivery.

Authorization to Release Protected:

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

	Check One	*Initial Each Line Below*
I ☐ **DO**	☐ **DO NOT** want information on ***Mental Health** to be released	_____
I ☐ **DO**	☐ **DO NOT** want information on ***HIV tests & Related information** to be released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ **DO**	☐ **DO NOT** want information about ***Communicable Diseases** released	_____

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If the form is incomplete, or if protected information is not released, we may be unable to fulfill this request

Patient's Signature_____ **Date:**_____

(Required for all patients 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian_____ **Date:**_____

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

-This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.

-I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.

-I understand that my treatment or continued treatment by PineappleHealth/Rejenesis and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.

-I understand that I may inspect or copy the information that is used or disclosed.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Revocation**: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED "A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."

By:_____ Physician or Duly Authorized Representative Signature	(Date)	By:_____ Patient's Signature	(Date)
By:_____ Print or Stamp Name of Physician, Medical Group or Association Name		By:_____ Print Patient's Name	
By:_____ Signature of Translator (if applicable)	(Date)	By:_____ Patient's Representative's Signature	(Date)
By:_____ Print Name of Translator		By:_____ Print Name and Relationship to Patient	

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

WELCOME TO PINEAPPLE HEALTH

Please take the time to **READ, SIGN, AND DATE** this financial policies form. If you feel that you need additional information or explanation regarding these policies, please refer to our **office brochure**, and our billing specialist will be glad to answer any questions.

We are contracted with many insurance plans. Under these plans the patient or responsible party may be required to pay deductible, co-pay, co-insurance for non-covered goods and services. **COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE or your appointment may be rescheduled!**

We accept **VISA and MASTER cards**. We also accept **MONEY ORDERS, CASHIER CHECKS and CASH**. We **DO NOT** accept PERSONAL CHECKS.

It is **YOUR RESPONSIBILTY** to know your insurance plan benefits. **ROUTINE PHYSICALS, IMMUNIZATIONS, WELL-CHILD CHECKS, certain LABORATORY TESTS, PROCEDURES, and PRESCRIBED MEDICATIONS, etc., may NOT BE COVERED.**

If a service is not covered by your plan, payment is due at time of service. We encourage you to contact your insurance carrier ahead of time and verify appropriate coverage. We will also require proof of insurance in the form of an insurance card, or in the case of a new policy a copy of the enrollment form specifying insurance company name and phone number, employer and his/her phone number, insured employee name, date of birth and social security number.

If we are not contracted with your insurance plan, **YOU** must pay in full at time of service. A copy of your driver's license will be taken. You will be given a copy of our charge slip to submit to your insurance for reimbursement purposes.

We submit our services to your insurance company as a courtesy to you. However, you are **RESPONSIBLE** for the balance of the account and any portion not paid for by your insurance, and you will receive a statement detailing the activity and balance on your account. You may need to contact your insurance carrier to find out why they have not made payment. Outstanding balances must be paid before scheduling another appointment.

Balances over **120 DAYS** due may be sent to a collection agency unless other arrangements have been made. A **$50** fee may be assessed on accounts placed in collections. If you require a payment plan, our office administrator will be glad to arrange this with you. A **$25** service fee will be charged for previously written returned checks due to insufficient funds.

If an appointment is missed without timely notice, a **$50** fee will be assessed to the account if a second No Show occurs.

There will be a **$50** charge for any letter written by our provider on behalf of a patient.

Please refer to our **office brochure** for additional information regarding our office policies.

Thank you for choosing our office for your healthcare needs.

I HAVE READ, AGREE, AND UNDERSTAND THE ABOVE POLICIES OF PINEAPPLE HEALTH, AND BY SIGNING BELOW I ACCEPT THESE RESPONSIBILITES:

_____ Patient/Responsible Party | Date

_____ Witness (Pineapple Health) | Date

Pineapple Health Narcotic Agreement

I, _____ understand that for the purpose of this document, “narcotics” includes but is not limited to: Percocet, Vicodin, Hydrocodone, Lortab, Norco, Morphine, OxyContin, OxyCodone, Xanax, Valium, Alprazolam, Clonazopam, Temazepam, Klonopin, Tramadol, Ultram, Dilaudid, Demerol, Fentanyl Patches, Codeine and Tussonex: ☐

I understand that narcotic medications come with serious side effects, including but not limited to: Addiction, increased tolerance, hyperalgesia, constipation, sexual side effects, dizziness, nausea, vomiting, impaired judgment, short-term memory loss and inability to drive or operate machinery. I understand that driving under the influence of narcotics can lead to car accidents and arrest for DUI: ☐

I understand, and agree to the fact, that Pineapple Health is not a pain management clinic and does not prescribe narcotics on an ongoing basis: ☐

It is my job as a patient to schedule myself an appointment with the proper specialist(s) before running out of medications, as this may be the only time I am prescribed narcotics from Pineapple Health: ☐

I understand that narcotics are to be taken exactly as prescribed and only on an as needed basis. I will not take them more frequently than prescribed, nor will I combine them with other medications without expressed consent from the provider or pharmacist: ☐

I understand that the strength, quantity and dosage instructions were written with my safety as the priority: ☐

I understand that Pineapple Health abides by all of the State Board Regulations: ☐

I understand that if a health care provider at Pineapple Health stops or lowers my dose of narcotics, it is done so with my health and safety in mind: ☐

I understand that no refills will ever be written for narcotics. If I need another script written for my narcotics, I will come in for an appointment. At that appointment, I will be evaluated and may or may not receive another script: ☐

I understand that coming in for an appointment does not guarantee a script will be written: ☐

I understand that carrying pills or a script for narcotics is a large responsibility. If anything happens to my script or pills, including but not limited to theft, loss or damage, I will under no circumstances be written a replacement script: ☐

_____ _____

Patient signature and date

Prescriber/Witness signature and date

Pineapple Health

All professional services rendered are charged to the patient. We do, as a courtesy, bill your insurance company. If you have no insurance coverage it is customary to pay for services when they are rendered, unless other arrangements have been made in advance. Ultimate responsibility of payment for services is the patient's.

For our Medicare patients we accept MEDICARE ASSIGNMENT as well as submit all claims to your supplemental insurance.

I authorize the physician to release any information required in the course of examination and permit payment directly to Pineapple Health for any services rendered. Regardless of insurance coverage, I recognize and accept responsibility for any remaining balance.

Signed: _____ Date: _____

Acknowledgement of Receipt of Privacy Notice

I understand that I am entitled to a copy of this notice of Privacy Practice

Print Name: _____ Date of Birth: _____

FFM Staff Name as witness: _____ Date: _____

Patient or Legally authorized person signature: _____ Relationship: (self, parent, legal guardian, etc.) _____ Date: _____

Pineapple Health

Notice of Privacy Practices

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of Pineapple Health to protect the privacy of your medical information.

We use the term "medical information" in this notice to mean your protected health information, 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 and other information related to your health care that we maintain about you.
We are required by law to:

- **Maintain the confidentiality of your medical information in accordance with applicable federal and/or state law;**
- **Comply with the terms of this notice until it is replaced with a new notice; and**
- **Give you this notice of our legal duties and privacy practices with respect to medical information we maintain about you.**

We reserve the right to change the terms of this notice at any time. We also reserve the right to make the changes apply to your medical information we already have.

How May We Use or Disclose Your Medical Information?
We may use and disclose your medical information without your authorization for treatment, payment, and health care operations as explained below:

For Treatment: **We may use and disclose your medical information to the physicians, nurses, and other health care personnel located at each of our facilities who provide, coordinate or manage your health care and any related services. For example, our doctors and nurses may use and disclose your medical information with each other to provide treatment to you. We may also disclose your medical information to another health care provider who is not located at one of our facilities, at his request, for your treatment by him. For example, your medical information may be provided to a doctor to whom you have been referred so that he may diagnose or treat you.**

For Payment: **We may use and disclose your medical information in order to bill and collect payment for the treatment and services provided to you. For instance, we may provide portions of your medical information to your health insurance plan to get paid for the health care services we provided to you. We may also disclose your medical information to your health insurance plan to permit it to make a determination of eligibility or coverage for insurance benefits, to review the services we provided to you for medical necessity, and to perform utilization review activities. We may also disclose medical information about you to the responsible party of your account. If you are listed as a dependent on another person's insurance policy, financial information regarding medical care provided may be mailed to that responsible party. In addition, if you do not timely pay us for the health care services we provided to you, we may also disclose limited medical information to a collection agency. We may also disclose your medical information to other health care providers, health plans or health care clearinghouses for their payment activities. For example, we may provide your medical information to an ambulance/transportation company that provided services to you.**

For Health Care Operations: **We may use and disclose your medical information in order to support our business activities, such as quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for our other business activities. For example, we may use your medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose your medical information to medical school students who see patients at our facilities. In addition, we may use and disclose your medical information to other health care providers, health plans or health care clearinghouses for their limited health care operations, such as quality assessment activities, licensing and other health care compliance activities.**

Below are other reasons we may use and disclose your medical information without your consent or authorization:

Uses and Disclosures Required by Law. **We may use or disclose your medical information as required by law, but must limit such use or disclosure to relevant information and otherwise comply with applicable legal requirements. We must also disclose your medical information to the Secretary of Health and Human Services to determine our compliance with federal privacy laws.**

Public Health Activities. **We may use or disclose your medical information to public health authorities authorized to receive or collect information for public health purposes, such as for preventing or controlling disease and certain regulatory activities of the Food and Drug Administration.**

Abuse, Neglect, or Domestic Violence**. We may use or disclose your medical information in some instances if we reasonably believe that you are a victim of abuse, neglect, or domestic violence.**

Health Oversight Activities. **We may use or disclose your medical information to a health oversight agency for health oversight activities authorized by law, including, for example, inspections and licensure of health care facilities.**

Judicial and Administrative Proceedings. **We may use or disclose your medical information under certain conditions to comply with legal proceedings, such as a subpoena or order by a court or administrative tribunal.**

Law Enforcement Purposes. **We may use or disclose your medical information for law enforcement purposes to law enforcement officials, such as for identification of suspects or where a crime has been committed on our premises.**

Decedents. **We may use or disclose medical information about decedents to coroners, medical examiners, and funeral directors.**

Organ, Eye, Tissue Donation. **We may use or disclose your medical information to notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.**

Research. **In limited circumstances, we may use and disclose your medical information to conduct medical research.**

Serious Safety Threat**. We may use or disclose your medical information where we believe it is necessary to prevent or lessen a serious threat to the safety of a person or the public.**

Special Government Functions. **We may use or disclose your health information under some circumstances for specialized government functions, including those related to the armed forces, national security, and intelligence.**

Workers' Compensation. **We may use or disclose your medical information as authorized by and to the extent necessary to comply with laws related to workers' compensation and similar programs.**

Scheduling Appointments, Appointment Reminders and Health Related Benefits or Services**. We may use and disclose your medical information to schedule appointments, give you appointment reminders, and give you information about treatment alternatives or other health care related services or benefits we offer.**

To Your Personal Representatives. **We may disclose your medical information to your personal representatives that are appointed by you or authorized by applicable law.**

Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. We may release such information for purposes that include (1) providing you with health care; (2) protecting your health and safety or the health and safety of others; or (3) protecting the safety and security of the correctional institution.**

Potential Impact of State Law
In some situations, the federal privacy laws do not preempt (or take precedence over) state privacy laws that give you greater privacy protections. As a result, the privacy laws of a particular state might impose a privacy standard under which we will be required to operate. For example, Alabama law may provide greater privacy protections to medical information related to artificial insemination records, sexually-transmitted diseases, and certain mental health records.

Individuals Involved in Your Care. **We may disclose your medical information to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity for you to agree or object may be given retroactively in emergency situations.**

Your Authorization Is Needed for Other Uses and Disclosures.
We will not use or disclose your medical information for any other purpose unless you give us written authorization to do so. If you give us written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information that we maintain, unless we have taken action in reliance on your authorization.

What Rights Do You Have Regarding Your Medical Information?
The Right to Request Additional Restrictions on Uses and Disclosures of Your Medical Information**. You have the right to ask that we put additional restrictions on how we use and disclose your medical information. We do not have to agree to your request.**
The Right to Inspect and Copy Your Medical Information. **You have the right to inspect and copy your medical information that we may use to make decisions about you. In limited circumstances, we do not have to agree to your request.**
The Right to Amend or Correct. **If you feel that your medical information is incorrect or incomplete, you have the right to ask us to correct or amend the information. We will require that you submit the request in writing and explain your reasons for asking for an amendment. In some cases, we do not have to agree to your request.**

The Right to Request Confidential Communications. **You have the right to request that we communicate with you about medical matters by a different means or at a different location than what we are currently doing. In limited circumstances, we do not have to agree to your request.**
Paper Copy of this Notice. **You have the right to request and receive a paper copy of this notice if you received it by email or on the Internet.**
The Right to an Accounting of Disclosures. **You have the right to request a list of certain disclosures that we and our business associates made for certain purposes for the last six (6) years.**

If you want to exercise any of these rights described in this notice, please contact our Contact Office (below). We will give you the necessary information and forms for you to complete and return to us. In some cases, we may charge you a nominal fee to carry out your request.

If you think we may have violated your privacy rights, you may file a complaint with our Contact Office (below). You also may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.
Our Contact Office: To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at the following Contact Office: Pineapple Health (480) 961-2366.