ALLIANCE SURGERY ARIZONA

Full Name:
Date of Birth:
Gender: Age:

# Patient Profile

## Patient Information

Patient Name: Last:_____ First:_____ Middle:_____ SSN:_____

Date of Birth:_____ Sex: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widow ❒ Other:_____

E-mail:_____ Preferred Method of Contact:_____

Phone Numbers: Home:_____ Work:_____ Cell:_____

Primary Address:_____ City:_____ State:_____ Zip:_____

Alternate Address:_____ City:_____ State:_____ Zip:_____

Race/Ethnicity: ❒ Asian ❒ Black/African American ❒ Caucasian ❒ Hispanic ❒ Native American ❒ Other:_____ ❒ Decline

Religion:_____ Language: ❒ English ❒ Spanish ❒ Other:_____

## Pharmacy Information

Pharmacy:_____ City:_____ Pharmacy Phone Number:_____

## Referring Physician and Primary Care Provider (PCP) Information

What provider referred you to our clinic today? Name:_____

Who is your primary care provider (PCP)? Name:_____

How did you hear about us? ❒ Physician Referral ❒ Friend/Family ❒ TV, Radio, Billboard, Print Ad ❒ Social Media (Facebook)
❒ Attended/Heard Community Event ❒ Convenience/Close to Home ❒ Dictated by Insurance ❒ None

## Employment Information

❒ Disabled ❒ Employed ❒ Retired ❒ Self-Employed ❒ Student ❒ Unemployed ❒ Other:_____

## Insurance Information

Primary Insurance:_____ Member ID:_____ Group #_____

Subscriber Name:_____ Relationship:_____

Secondary Insurance:_____ Member ID:_____ Group #_____

Subscriber Name:_____ Relationship:_____

## Emergency Contact Information

Name: Last:_____ First:_____ Relationship:_____

Phone Numbers: Home:_____ Cell:_____



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ALLIANCE SURGERY ARIZONA

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**Reason for Visit:**_____

## Medications

_____

_____

_____

_____

_____

## Allergies

_____

_____

## Medical History

- ❒ Diabetes
- ❒ Hypertension/ High Blood Pressure
- ❒ High Cholesterol
- ❒ Thyroid Problems
- ❒ Heart Disease
- ❒ Stroke
- ❒ Heart Attack
- ❒ Heart Catheterization or Ultrasound
- ❒ Artery Catheterization or Ultrasound
- ❒ Serious Infection Problems
- ❒ Bleeding Disorder/Clotting
- ❒ Anesthesia Problems
- ❒ Seizures
- ❒ Stomach or Intestinal Problems
- ❒ Kidney Disease
- ❒ Tuberculosis
- ❒ Asthma
- ❒ Pneumonia
- ❒ Rheumatic Fever
- ❒ Jaundice
- ❒ Hepatitis
- ❒ STDs
- ❒ Other Medical Diagnosis:

_____

_____

Have you ever had a mammogram? ❒ No ❒ Yes, date:_____

Have you ever had a colonoscopy? ❒ No ❒ Yes, date:_____

Do you have a Pacemaker? ❒ No ❒ Yes, date of most recent check-up:_____

## Surgeries

Procedure:_____ Date:_____

Procedure:_____ Date:_____

Procedure:_____ Date:_____

Procedure:_____ Date:_____

## Social History

Are you a current smoker? ❒ No ❒ Yes, how much per day/week?_____

Previous smoker? ❒ No ❒ Yes, when?_____

Do you drink alcohol? ❒ No ❒ Yes, how much per day/week?_____

Do you use illicit/recreational drugs? ❒ No ❒ Yes, how much per day/week?_____

## Pain Assessment

Do you have pain now? ❒ No ❒ Yes

Pain level that best describes your pain at its worst in the past 24 hours:_____ (1=low, 10=high)



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## Family History

| | | | |
|---|---|---|---|
| Heart Problems/Murmurs | Relationship:_____ | ❒ Maternal | ❒ Paternal |
| Allergy | Relationship:_____ | ❒ Maternal | ❒ Paternal |
| Diabetes | Relationship:_____ | ❒ Maternal | ❒ Paternal |
| Cancer | Relationship:_____ Type:_____ | ❒ Maternal | ❒ Paternal |
| Bleeding Disorder | Relationship:_____ | ❒ Maternal | ❒ Paternal |
| Disease Type | Relationship:_____ | ❒ Maternal | ❒ Paternal |

## Current Symptoms – Check All That Apply

| | |
|---|---|
| Breast: | ❒ Lump/Mass ❒ Nipple Discharge ❒ Nipple Inversion ❒ Pain |
| Cardiovascular: | ❒ Chest Pain ❒ Edema/Swelling ❒ Palpitations |
| General/Constitutional: | ❒ Fatigue ❒ Night Sweats ❒ Chills ❒ Weight Changes |
| Endocrine: | ❒ Thyroid Disease |
| Eyes: | ❒ Vision Problems ❒ Vision Changes |
| Gastrointestinal: | ❒ Abdominal Pain ❒ Constipation ❒ Diarrhea ❒ Heartburn ❒ Hemorrhoids ❒ Rectal Bleeding ❒ Nausea ❒ Pain/Cramping ❒ Vomiting |
| Genitourinary: | ❒ Frequent Urination ❒ Painful Urination/Dysuria ❒ Scrotal Swelling |
| Hematologic/Lymphatic: | ❒ Easy Bruising ❒ Swollen Glands ❒ Bleeding Problems |
| Skin/Integumentary: | ❒ Rash ❒ Hives ❒ Itching ❒ Hair Changes ❒ Skin Changes |
| Muscular: | ❒ Joint Aches ❒ Muscle Weakness |
| Neurological: | ❒ Headaches ❒ Loss of Consciousness ❒ Weakness ❒ Numbness ❒ Tingling |
| Respiratory: | ❒ Cough ❒ Coughing Blood ❒ Wheezing ❒ Difficulty Breathing ❒ Asthma |
| Allergies: | ❒ Environmental ❒ Chronic |
| Psychological: | ❒ Depression ❒ Anxiety or Panic |

The undersigned patient _____(Patient Name) hereby consents to the examination, treatment, procedures, and services to be performed by *Alliance Surgery Arizona Credentialed Practitioners*, including emergency treatment.

**X**_____ _____
Signature of Patient or Authorized Representative Date Signed



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Full Name:
Date of Birth:
Gender: Age:

# Authorization to Release/Receive Information

The use and disclosure of your personal "Protected Health Information" (PHI) is regulated by the "Health Insurance Portability and Accountability Act of 1996" (HIPPA). Pursuant to HIPPA regulations, we are not permitted to discuss your PHI with family or friends unless you give us permission. You may designate below family or friends with whom you authorize us to discuss your PHI. You may revoke your authorization at any time if you change your mind. Please refer to our Notice of Privacy Practices for additional information about how to revoke your authorization and other permitted uses and disclosures of your PHI.

Please list the names of persons with which we are allowed to speak and their relation to you. Please let them know that they will be required to verify their identity and verify *your* name, social security number, and birthday before any information may be released.

1. _____ **Relation:**_____ **Phone:**_____

2. _____ **Relation:**_____ **Phone:**_____

3. _____ **Relation:**_____ **Phone:**_____

4. _____ **Relation:**_____ **Phone:**_____

5. _____ **Relation:**_____ **Phone:**_____

If you have any questions, please see the "Notice of Privacy Practices" form or ask the office staff.

Thank you.

**X** _____ _____

Signature of Patient Date



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# Authorization to Release Information and Assignment of Benefits

(A copy shall be valid as the original)

Please read the following information as it applies to you. During the course of your care, you will receive a statement from Alliance Surgery Arizona for the services performed. We will file all insurance claims in our office, and the insurance companies will send payments directly to us for our services provided to you. We will also file any secondary insurance if you have other coverage.

You will be responsible for any services not covered by your insurance. Services are only covered as long as you are eligible according to your insurance plan.

We will accept the Medicare allowed amount for services; however, Medicare pays 80% of eligible charges, and the patient is responsible for the remaining 20% unless you have secondary insurance, which we will be glad to file for you. All other insurance's pay according to the plan you have during your eligible dates, which may leave a balance for which you may be responsible. If you have any questions regarding your plan, please call your insurance company. We want to help you understand our billing procedures and will be happy to assist you in any way we can. If you have any questions regarding your account with us, please call our billing office at 1-877-451-4959.

It is extremely important that you keep us informed of any changes in your insurance coverage as soon as possible.

**MEDICARE**

I authorize Alliance Surgery Arizona to release any information needed to the Social Security Administration or its intermediaries or carriers for the purpose of filing claims. I request that my insurance payments be made directly to Alliance Surgery Arizona for the services provided, and I acknowledge that I am financially responsible for any unpaid balance.

**MEDICAID**

I authorize Alliance Surgery Arizona to release any information needed to the Medicaid intermediary or carrier for the purpose of filing claims. I request that payment of benefits be made directly to Alliance Surgery Arizona. I acknowledge that I am financially responsible for any services provided on any date for which I am not Medicaid eligible, as well as any spend-down amounts.

**INSURANCE CARRIER**

I authorize Alliance Surgery Arizona to release any information needed to my insurance carrier for the purpose of filing claims. I authorize the insurance payments to be made directly to Alliance Surgery Arizona for the services provided, and I acknowledge that I am financially responsible for any unpaid balance.

**X**

Signature of Patient or Authorized Representative

Relation to Patient

Physician's Representative

Date Signed

*Alliance Surgery Arizona does not deny benefits or services because of race, color, national origin, age, sex, disability, religious, or political beliefs.*

# Release of Records

Patient Name: Last:_____ First:_____ Middle:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

I hereby authorize:_____
*Name of Physician, Facility, or person*

Located at:_____ City:_____ State:_____ Zip:_____

To release protected health information contained in the medical record of the patient to the following facility:

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**Information to be Released:**

Dates of Treatment to be Released: From_____ to _____

❒ Laboratory Result ❒ Imaging (Reports Only) ❒ Office Notes ❒ Pathology

❒ Complete Records ❒ Other:_____

Purpose of Release: ❒ Medical Care ❒ Other:_____

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not re-disclose my health information to a third party. Such a third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.

I understand that I may refuse to sign or revoke this authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment. I understand that this authorization will expire 90 days from the date of this authorization unless I provide written notice of revocation to the releasing facility noted above.

X

Signature of Patient or Authorized Representative

Relation to Patient

ALLIANCE SURGERY ARIZONA

Full Name:
Date of Birth:
Gender: Age:

# Notice of Privacy Rights & Practices
# Acknowledgment Statement

We are required by a federal law known as "The Health Insurance Portability and Accountability Act" (HIPAA) as well as by Arizona law to maintain the privacy of your medical and health information, also referred to as "Protected Health Information" (PHI).

Our Notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the Notice (or any other Notice in effect at the time of the use or disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree to this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your Signature below constitutes your acknowledgment that you have received a copy of our Notice of Privacy Rights and Practices and your consent under Arizona law to the kinds of uses and disclosures of PHI mentioned in our Notice.

X

Patient's Signature _____ Date _____

Personal Representative _____ Date _____

Relationship to Patient _____

Signature of Interpreter _____ Date _____



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# 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.**

***"Protected Health Information"*** is information about you, including demographic information, that may identify you, and that relates to your past, present, or future health care related services. This Notice of Privacy Practices describes how Alliance may use and disclose your Protected Health Information for treatment, payment, and health care operations. It also discusses other purposes permitted or required by law. Additionally, this Notice describes your rights of access and control of your Protected Health Information.

Alliance HealthCare Services, Inc., its subsidiaries, and affiliates (collectively, "**Alliance**") is required by law to maintain the privacy of your Protected Health Information and to provide you with this Notice of our legal duties and privacy practices concerning your Protected Health Information. We are also required to comply with this Notice of Privacy Practices. We may change its terms in the future, and the revised Notice of Privacy Practices will then be effective for all Protected Health Information maintained on or after that date. Our most current Notice of Privacy Practices, as may be revised, is posted on our website – **www.AllianceHealthCareServices-us.com**. You may also obtain a copy of our most current Notice of Privacy Practices at your next appointment, or you may ask our Privacy Official to send a printed copy to you.

If you have any questions about this Notice of Privacy Practices, please contact the Alliance Privacy Official at **(949) 242-5854** or via email sent to **Privacy@AllianceHealthCareServices-us.com**.

**1. Uses and Disclosures of Your Protected Health Information**

**Permitted Routine Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Your Protected Health Information will be used and disclosed to support your care and treatment, to ensure that we will receive payment for charges, and to support our administrative operations.

***Descriptions and examples of these permitted routine uses and disclosures include:***

**Treatment:** We will use and disclose your Protected Health Information so that we can provide services to you and to allow us to work with others assisting us with your care. For example, we may disclose your Protected Health Information to your physicians to give them the information necessary to diagnose and treat your condition. We may also disclose your Protected Health Information to others, such as pharmacy, medical record, and radiology entities, as necessary.

**Payment:** We will use your Protected Health Information so that we can obtain payment for our services. Your insurance carrier may require us to disclose your Protected Health Information before and/or after the provided services. This may include determination of eligibility, verification of your insurance benefits, determination of medical necessity, pre-authorization, and insurance billing.

**Health Care Operations:** We will use your Protected Health Information for the effective and efficient delivery of services to you. This includes quality assessment, employee training, support and maintenance of our equipment and systems, organization accreditation, and coordination with our business partners and suppliers.

Specifically, we may disclose your Protected Health Information to the facility where you are obtaining your services to allow the local storage of scan films and/or patient records. Before your appointment, we may contact you by telephone to confirm its time and location. At the time of your appointment, you may be asked to sign in, and we may call you by name when it is time for you to be seen. We may also share your Protected Health Information with third-party business associates that perform certain activities (e.g., billing, transcription services, billing and collections, etc.) on our behalf. In these instances, Alliance will have written agreements in place to protect the privacy of your Protected Health Information.

**Possible Uses and Disclosures for Which You Do Not Have an Opportunity to Object**

Some circumstances require Alliance to use or disclose your Protected Health Information. We must do so without your authorization, and you will not have the opportunity to object.

***General situations include:***

**When Required by Law:** We may use or disclose your Protected Health Information to the limited extent required by law. You will be notified, if required by law, of any such uses or disclosures.

**To Demonstrate Our Compliance:** The U.S. Department of Health and Human Services or other regulatory agency may require us to disclose your Protected Health Information so that we can demonstrate our compliance with laws or if non-compliance is suspected.

***Specific situations include:***

**Abuse or Neglect:** Consistent with applicable federal and state laws, we may provide your Protected Health Information to a public health, civil authority, or government agency when child abuse, neglect, or domestic violence may have occurred if 1) law requires the disclosure, 2) you agree to the disclosure, 3) law allows the disclosure and the disclosure is needed to prevent potential serious harm to you or someone else, or 4) law allows the disclosure, you are unable to agree or disagree, the information is needed for immediate action, and the information will not be used against you.

**Criminal Activity:** We may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Law Enforcement:** We may disclose Protected Health Information for law enforcement purposes. These purposes include 1) limited information requests for suspect identification and location, 2) identifying victims or researching victims of a crime, 3) suspicion of criminal conduct related to a death, 4) investigation of a crime that occurred on our premises, and 5) when a medical emergency has occurred off of our premises, and it is likely that a crime has been committed.

**Legal Proceedings:** We may disclose Protected Health Information in judicial or administrative proceedings, in response to a court order or administrative hearing (if expressly authorized), and, in certain conditions, in response to a subpoena, discovery request, or another lawful process.

**Public Health:** We may disclose your Protected Health Information to a public health authority for public health activities such as controlling disease, injury, or disability.

**Communicable Diseases:** We may disclose your Protected Health Information to a person who may have been exposed to certain communicable diseases or may be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose Protected Health Information to health oversight, regulatory, and accreditation agencies for purposes such as audits, investigations, and inspections.

**Food and Drug Administration:** We may disclose your Protected Health Information as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products (to enable product recalls, repairs, or replacements), or to perform oversight activities.

**Inmates:** If you are in custody, we may disclose your Protected Health Information to your correctional facility or to law enforcement entities related to your care to ensure the health and safety of others related to your custody or institution, or to maintain the safety, security, law and order of the facility.

**Workers' Compensation:** We may disclose your Protected Health Information to comply with workers' compensation laws and other similar programs.

**National Security and Military Activities:** We may disclose your Protected Health Information to federal officials authorized to conduct national security and intelligence activities. If you are in the Armed Forces, we may disclose your Protected Health Information 1) for activities deemed necessary by command authorities, 2) for benefits eligibility determination by the Department of Veterans Affairs, or 3) to a foreign military authority (if you are a member of their military service).

**Possible Uses and Disclosures for Which You May Object**

**Employment-Related Disclosure:** We may disclose your Protected Health Information to your employer if 1) we provide health care services to you at the request of your employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury, 2) you Protected Health Information that is disclosed consists of findings concerning a work-related illness or injury or workplace-related medical surveillance, 3) your employer needs such findings in order to comply with its obligations under applicable law to record such illnesses or injury to carry out responsibilities for workplace medical surveillance, and 4) we provide written notice to you at the time the health care services are provided that PHI relating to the medical surveillance of the workplace and work-related injuries is disclosed to your employer.

**Student Immunization:** We may disclosure your Protected Health Information to a school about you if you are a student or prospective student of the school, concerning proof of immunization.

If the use or disclosure of your Protected Health Information is not routinely permitted or legally required, you may have the opportunity to impose limitations on its use and disclosure.

***Specifically, you may limit:***

**Disclosure to Family Members, Relatives, or Personal Representatives:** Unless you request limitations, we may disclose your Protected Health Information to members of your immediate family, other relatives, or your legally designated health care decision-maker. We will limit disclosures to information directly related to their involvement in your health care. You may prevent this disclosure, or you may seek to limit it. You may also designate someone other than those listed above (such as a close personal friend) to whom we may disclose your Protected Health Information.

If you are physically unable to express your objection or limitation, we will proceed as noted above if we believe that doing so is in your best interest. If a family member, relative, or personal representative is not present, we may use your Protected Health Information to identify a representative. In the case of emergencies and disasters, we may disclose your Protected Health Information to authorized entities assisting in response and relief efforts.

**Fundraising**

Your Protected Health Information may be used and disclosed for communications to raise funds for Alliance, but you have a right to opt out of receiving such communications. Any such fundraising communication to you will include the opt-out mechanism.

**Uses and Disclosures Permitted Only with Your Written Authorization**

In situations not covered above, use or disclosure of your Protected Health Information will occur only with your written authorization. These cases include requests you make to Alliance, as well as those we may receive from third parties. For example, you may request that we disclose some or all of your Protected Health Information to an attorney, consultant, or personal acquaintance. Similarly, Alliance may receive a request from a third party to disclose your Protected Health Information. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your Protected Health Information for marketing purposes, and disclosures that constitute a sale of your Protected Health Information require your written authorization.

Further, certain federal and state laws require special privacy protections for certain "Highly Confidential Information" about you, including the subset of your Protected Health Information that 1) is maintained in psychotherapy notes, 2) is about mental health and developmental disabilities services, 3) is about alcohol and drug abuse prevention and treatment, 4) is about HIV/AIDS testing, diagnosis, or treatment, 5) is about communicable disease(s), 6) is about genetic testing, or 7) is about sexual assault. In order for us to use or disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

You may later revoke your authorization in writing if you change your mind. Should you change your mind, your revocation will only be effective to the extent we have not previously relied on your revocation in making disclosures of your Protected Health Information.

**2. Your Rights – These Are Your Privacy Rights and How You Can Exercise Them:**

**You have the right to obtain a printed copy of this Notice.** You may obtain a copy of this Notice at the time of your appointment, or you may contact our Privacy Official at any time to request that a copy be sent to you.

**You have the right to inspect and copy your Protected Health Information.** You may review and receive a copy of your Protected Health Information contained in our Designated Record Set for as long as we maintain the records. A Designated Record Set contains medical, billing, and any other records that Alliance uses for making clinical and financial decisions about you.

Requests to inspect or obtain your records must be submitted in writing on a record request form to our Privacy Official. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If we maintain your Protected Health Information in one or more Designated Record Sets electronically, and if you request an electronic copy of your Protected Health Information, we will provide you with a copy of your Protected Health Information in the electronic form and format that you request, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed upon by you and us. If you provide us with clear, conspicuous, and specific directions, we will send a copy of your Protected Health Information (hard copy or electronic) directly to another person of your choosing. We may charge you a reasonable, cost-based fee for any requested copies.

**You have the right to request that we amend your Protected Health Information.** Should you disagree with any Protected Heath Information maintained in our Designated Record Set, you may request in writing to our Privacy Official that we change it for as long as we maintain it. Alliance is not required to make the changes you request. If your request is denied, you have the right to file a statement of disagreement with our Privacy Official, and we may prepare a rebuttal. You will be provided with a copy of any rebuttal; copies of related correspondence will be included with your Protected Health Information. If you do not submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of PHI that is the subject of the amendment.

**You have the right to request how we provide confidential communications to you.** You may request special handling for communication of confidential matters. All such requests must be submitted in writing to our Privacy Official. Alliance will accommodate reasonable requests, and we will not require you to provide a reason or explanation for your request. We may, as a condition for our agreement, require you to provide additional contact information or other assurances regarding payment of your health care charges.

**You have the right to request restrictions relating to your Protected Health Information.** You may request restrictions on the use or disclosure of your Protected Health Information. Requests must be in writing and specify 1) the specific restriction requested and 2) to whom you wish it to apply. Before and during your appointment, you may make the request to any Alliance employee you contact. After your appointment, restriction requests must be forwarded to our Privacy Official.

Alliance is not required to agree to all restriction requests. If we agree to the restriction, we will not use or disclose your Protected Health Information in violation of the restriction unless it is necessary to provide emergency treatment to you. The restriction will take effect after it has been approved. A restriction to which we agree does not prevent any uses or disclosures specified in the above section, "Possible Uses and Disclosures for Which You Do Not Have an Opportunity to Object."

Upon your written request, except as otherwise required by law, Alliance will restrict disclosures of Protected Health Information to a health plan 1) for purposes of carrying out payment or 2) for purposes of carrying out health care operations (but not for purposes of carrying out treatment). Requests will not be honored unless the Protected Heath Information pertains solely to a health care item or service for which you, or person acting on your behalf (other than the health plan), has paid Alliance out of pocket in full.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information.** Your request must be submitted in writing to our Privacy Official. The accounting excludes disclosures for treatment, payment, or health care operations as described in this Notice. It also excludes disclosures we may have made to you, your family members, or designated representatives. Other exceptions, restrictions, and limitations may also apply. The accounting will cover a maximum period of six years. You may request a shorter period for the accounting. After the first request for an accounting within a 12-month period, we may charge you a reasonable, cost-based fee.

**You have the right to be notified of a breach of your unsecured Protected Health Information.** Alliance will notify you in writing of any such breach (i.e., an unauthorized acquisition, access, use, or disclosure) of your unsecured (i.e., unencrypted) Protected Health Information.

**3. Complaints**

If you believe that your privacy rights have been violated, you may file a complaint either with Alliance or with the Secretary of the U.S. Department of Health and Human Services. Alliance supports your right to file a complaint and will not take any adverse action against you for doing so.

To file a complaint with Alliance or for additional information about the complaint process, contact the Alliance Privacy Official at **(949) 242-5854** or via email sent to **Privacy@AllianceHealthCareServices-us.com**.

To file a complaint with the Secretary of the U.S. Department of Health and Human Services, contact:

**Director**
**Office for Civil Rights**
**U.S. Department of Health and Human Services**
**200 Independence Avenue, SW**
**Room 509F HHH Bldg.**
**Washington, DC 20201**

This Notice is published and effective on August 23, 2013 Attachment A00