

JATEKO Family Medical Group

Jeaniene A. Talley, M.D., FAAFP

Welcome to our practice!

After Office Hours

For urgent medical issues after regular office hours, please call our office number to be connected to the on-call doctor's paging service. For all other issues, please call us during our regular office hours.

Same Day / Urgent Appointments

We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let us know and we will try to accommodate you on the same or following day.

Emergencies

Call 911 for medical emergencies.

Medication Refills

We do not want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" when you are picking up your last refill. If you prefer to call us, please call us during our regular office hours and allow 3-4 working days for us to refill your medications.

Forms

Please make an appointment if you have any forms that will require our doctors to fill out. Most forms require an evaluation and possible laboratory testing to complete.

Medical Care

We are concerned about your health. In order for us to provide the best possible quality of care for you, we will need your cooperation in keeping your scheduled appointments, making follow up appointments, scheduling annual physical exams, and completing tests ordered for you.

Canceling Appointments

If for any reason you will not be able to keep your appointment, we ask that you notify us to reschedule at least 24 hours prior to your appointment.

Other Physicians or Health Care Specialists

If you are seeking healthcare from other physicians in the community, we would like you to ask their office to send us a copy of their notes and studies.

Communication

We believe in having good communication between our office staff and our patients. We encourage you express any questions or concerns to us so we may better serve you.

**All New Patient Forms must be completed and signed at or prior to your first appointment.*

PATIENT INFORMATION

LAST NAME		FIRST NAME	M.I.	NAME YOU PREFER TO BE CALLED	SEX
ADDRESS		APT #	CITY	STATE	ZIP
SOCIAL SECURITY #	BIRTHDATE	HOME TELEPHONE #		CELL PHONE #	
WORK TELEPHONE #			E-MAIL ADDRESS		
EMPLOYER		EMPLOYER ADDRESS		POSITION/ TITLE	
HOW DID YOU HEAR ABOUT US?					
EMERGENCY CONTACT NAME & TELEPHONE NUMBERS					
WHO WAS YOUR PREVIOUS PRIMARY PHYSICIAN?			TELEPHONE #		
PHYSICIAN ADDRESS					

GUARANTOR/ POLICY HOLDER INFORMATION

LAST		FIRST NAME	M.I.	RELATIONSHIP TO PATIENT	
				SPOUSE	PARENT OTHER:
ADDRESS IF DIFFERENT FROM PATIENT					
BIRTH DATE		SOCIAL SECURITY #			
GUARANTOR/ POLICY HOLDER'S EMPLOYER		EMPLOYERS ADDRESS		CITY	STATE ZIP

INSURANCE INFORMATION

1.PRIMARY INSURANCE PLAN		GROUP NUMBER	POLICY NUMBER
TYPE OF PLAN OR COVERAGE			
HMO	PPO	EPO	MEDI-CAL
MEDICARE	MEDICARE SUPPLEMENT	CASH	OTHER
POLICY OWNERS NAME (GUARANTOR)		IPA	PRIMARY CARE PROVIDER
2.SECONDARY INSURANCE PLAN		GROUP NUMBER	POLICY NUMBER
TYPE OF PLAN OR COVERAGE			
HMO	PPO	EPO	MEDI-CAL
MEDICARE	MEDICARE SUPPLEMENT	CASH	OTHER
POLICY OWNERS NAME (GUARANTOR)		IPA	PRIMARY CARE PROVIDER

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Jateko Family Medical Group. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Jateko Family Medical Group. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.) There is a \$20.00 charge for all returned checks. All unpaid balances are subject to 1.5% interest or minimum \$6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

PATIENTS SIGNATURE _____ GUARANTORS SIGNATURE _____ DATE _____

HEALTH HISTORY FORM

Patient Name: _____

Date of Birth: _____

Personal Medical History: Have you ever had (please circle all answers Yes or No)

High Blood Pressure	No	Yes	Anxiety	No	Yes	Pneumonia	No	Yes
Heart Disease	No	Yes	Depression	No	Yes	Meningitis	No	Yes
Heart Murmur	No	Yes	Epilepsy	No	Yes	Gonorrhea	No	Yes
High Cholesterol	No	Yes	Osteoporosis	No	Yes	Chlamydia	No	Yes
Diabetes	No	Yes	Thyroid Disease	No	Yes	Syphilis	No	Yes
Anemia	No	Yes	Asthma	No	Yes	Genital Herpes	No	Yes
Stomach pain or Reflux	No	Yes	Hives or Eczema	No	Yes	Genital Warts	No	Yes
Arthritis or Rheumatism	No	Yes	Migraines	No	Yes	Tuberculosis	No	Yes
Kidney disease	No	Yes	Gallbladder Disease	No	Yes	AIDS/HIV	No	Yes
Neuritis or Neuralgia	No	Yes	Colitis or other Bowel Disease	No	Yes			
Bone or Joint disease	No	Yes	Jaundice or Liver Disease	No	Yes			
Sciatica, Back pain	No	Yes	Cancer *	No	Yes	* Type of Cancer:	_____	

If "yes" to any of the above, please describe further: _____

Other Medical Problems & Surgeries:

List All Current Medication and Dosages: (include non-prescription)

Allergies to medications or food:

Describe the allergic reaction:

Do you drink alcohol? No Yes
Do you or have you ever smoked? No Yes
Do you use drugs? No Yes

Number of drinks _____ per week Quit date: _____
How many cigarettes per day: _____ How many years: _____
Quit date: _____
What kind: _____ How many years: _____

Are you currently(circle one): Married Single Divorced Widowed

How many children do you have? _____ Ages: _____

Occupation: _____ Employer: _____ Highest level of education: _____

Please list the last date you had any of the following:

Pap Smear _____ Date of Last Menstruation _____ Prostate Exam _____

Bone Density _____ Mammogram _____ Colonoscopy _____

Family Medical History: *example: cancer (type), diabetes, heart disease, mental illness, stroke, seizure, etc.*

Father: _____ Paternal grandfather: _____

Mother: _____ Paternal grandmother: _____

Siblings: _____ Maternal grandfather: _____

_____ Maternal grandmother: _____

PATIENT RESPONSIBILITIES

As a partner in your healthcare, you have the following responsibilities:

1. I will provide accurate health information to your doctor and update us with any health changes.
2. I will schedule routine physical exams and other health maintenance exams recommended to me by my doctor (pap smear, mammogram, bone density, colonoscopy, routine blood tests, immunizations, etc.). I put myself at risk for not detecting other medical diseases if I only see my doctor for immediate problems. I will make appointments with my doctor to discuss routine health screenings.
3. I will follow treatment plans recommended to me by my physician, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that *not* following my treatment plans may put my health at risk.
4. I will keep my appointments and reschedule any missed appointments. I understand that my doctor schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. During these appointments my physician may order tests, refer me to a specialist, change my medications, and diagnose a medical problem. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.
5. I understand that the goal of the office is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessary mean that the test result is normal.
6. I will inform my doctor if my medical condition changes, does not improve, or worsens. This will allow my doctor to re-evaluate my condition and make changes in treatment. If I do not inform my doctor, I may put my health at risk.
7. I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises.
8. I will treat all providers and office staff respectfully and courteously.
9. I will fulfill my financial obligations for care provided to me in a timely manner.
10. I will keep my scheduled appointments and give adequate notice of rescheduling or cancellation.
11. I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.
12. If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

I have been informed of my responsibilities and I understand them fully.

Print Name: _____ Date: _____

Signature: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Jateko Family Medical Group** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Jateko Family Medical Group** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Jateko Family Medical Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Jateko Family Medical Group**

With this consent **Jateko Family Medical Group** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Jateko Family Medical Group** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Jateko Family Medical Group** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that **Jateko Family Medical Group** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Jateko Family Medical Group** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Jateko Family Medical Group** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

Print Patient's Name

Print Name of Legal Guardian, if applicable

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize **Jateko Family Medical Group** to use and/or disclose certain protected health information (PHI) about me to :

Name: _____

Address: _____

This authorization permits **Jateko Family Medical Group** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as “at the request of the individual.”)
The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Jateko Family Medical Group**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

**Jateko Family Medical Group
6850 North Durango Drive, Suite 400
Las Vegas, NV 89149**

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Print Patient’s Name Date

Print Name of Legal Guardian, if applicable

Patient/guardian is entitled to receive a signed copy of this authorization form.

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JATEKO FMG

ULTRASOUND IMAGING / MOBILE IMAGING & DIAGNOSTICS

FOR OFFICE / CLINIC APPOINTMENTS

All appointments must have 24 hour notice to cancel.

For appointments with Dr. Talley, a cancellation fee of \$25 will be charged if the appointment is cancelled with less than 24 hour notice.

For Ultrasound / Nerve Conduction appointments, if you do not cancel by the deadline, you will be assessed an \$85 missed appointment fee. This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay at the time of your next visit. Our aim is to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated as we institute this policy.

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement and appointment / cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

NOTICE OF PRIVACY PRACTICES

Jateko Family Medical Group

Effective Date: June 1, 2008

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact: Jateko Family Medical Group 6850 North Durango Drive, Suite 400 Las Vegas, NV 89149.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members.

Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Jateko Family Medical Group 6850 North Durango**

Drive, Suite 400, Las Vegas, NV 89149, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Jateko Family Medical Group 6850 North Durango Drive, Suite 400, Las Vegas, NV 89149**.

Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Jateko Family Medical Group 6850 North Durango Drive, Suite 400, Las Vegas, NV 89149** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Jateko Family Medical Group 6850 North Durango Drive, Suite 400, Las Vegas, NV 89149**.

You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Jateko Family Medical Group 6850 North Durango Drive, Suite 400, Las Vegas, NV 89149**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Jateko Family Medical Group 702-474-4110**

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Jateko Family Medical Group 702-474-4110**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note:* we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Jateko Family Medical Group 702-474-4110**.

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