6788 S. Kings Ranch Road, Suite 1
Gold Canyon, AZ 85118
P: 480 626 4999
F: 480 304 3239
www.goldcanyonim.com

“Uncompromising Excellence. Commitment to Personalized care”

Welcome to Gold Canyon Internal Medicine,

Thank you for taking the time to fill out the following forms for your medical records with our office. This will make your first time visit a more pleasurable experience, with less waiting time.

Please remember to bring all prescription, and non-prescription drugs you are taking, along with your insurance cards, and photo identification.

Please review the check list of forms:

- Patient Registration
- Health History Questionnaire
- Authorization to Release Health Care Information
- HIPAA Notice of Privacy Practices
- Acknowledgement of Notice of Privacy Practices and Consent for Treatment
- Financial Policy

We look forward to meeting you and sincerely hope that your medical care with our office is a pleasant and positive experience. If you have any questions, please do not hesitate to call our office.

Sincerely,

The Staff of Gold Canyon Internal Medicine

Gold Canyon Internal Medicine
REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Social Security no.:	Home phone no.:	Mobile phone no.:	Work phone no.: ( )

Primary Address	City:	State:	ZIP Code:
Secondary Address	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Language: ☐ English ☐ Spanish ☐ Other:

Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian ☐ Asian ☐ Alaska native ☐ Native Hawaiian/Pacific Islander ☐ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of primary insurance	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gold Canyon Internal Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Original Date: 01/30/2018
Dates Revised:

Gold Canyon Internal Medicine
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam or annual wellness visit:**	

CHILDHOOD ILLNESSES AND IMMUNIZATIONS

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	Tetanus	☐ Tdap (*Tetanus/diphtheria/Pertussis)*	☐ Td (*Tetanus/diphtheria)*
	Pneumonia	☐ Pneumovax	☐ Prevnar 13
	Hepatitis	☐ Hepatitis A	☐ Hepatitis B
	☐ Influenza	☐ HPV/Gardasil	☐ MMR *Measles, Mumps, Rubella*
	☐ Zostavax (Shingles)	☐ Chickenpox (Varicella)	
	☐ Other		

MEDICAL HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐	Acid Reflux	☐	Heart murmur	☐	Osteoporosis or Osteopenia
☐	Anemia	☐	Hemorrhoids	☐	Pacemaker or Defibrillator
☐	Arthritis	☐	Hernias	☐	Pneumonia
☐	Asthma	☐	High cholesterol	☐	Seizure disorder
☐	Bleeding Disorder	☐	HIV	☐	Shingles
☐	Blood Clots	☐	Hypertension	☐	Sinusitis
☐	Bronchitis	☐	Irregular heart beat	☐	Skin disease
☐	Cancer (type)	☐	Irritable bowel	☐	Sleep apnea
☐	Colitis	☐	Kidney disease	☐	STI (Sexually Transmitted Infection)
☐	Colon Polyps	☐	Liver disease	☐	Stomach Ulcers
☐	COPD	☐	Lupus	☐	Stroke or TIA
☐	Diabetes	☐	Lyme disease	☐	Thyroid disorder
☐	Diverticulosis/Diverticulitis	☐	Meningitis	☐	Tremors
☐	Eye disorder	☐	Migraine	☐	Valley fever
☐	Heart attack	☐	Nasal allergies	☐	Varicose veins

Have you ever had a blood transfusion?	☐ No	☐ Yes

Please turn to next page

Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs, inhalers and over-the-counter drugs such as vitamins		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY					
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ High	☐ Med	☐ Low	
	Rank fat intake	☐ High	☐ Med	☐ Low	

HEALTH HABITS AND PERSONAL SAFETY (continued)						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will? If yes, please provide a copy.				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

REVIEW OF SYSTEMS		
Most of the following medical problems will probably **NOT** apply to you. Check items that **DO** apply at the present time.		
☐ Fever	☐ Difficulty Swallowing	☐ Blood in the stool
☐ Chills	☐ Painful Swallowing	☐ Black tarry stools
☐ Sweating at night	☐ Cough	☐ Constipation
☐ Weakness	☐ Shortness of Breath	☐ Diarrhea
☐ Fatigue	☐ Wheezing	☐ Assistive Device (Cane/Walker/Wheelchair)
☐ Weight gain *(more than 10 lbs. in the past year)*	☐ Chest Pain	☐ Dizziness
☐ Weight loss *(more than 10 lbs. in the past year)*	☐ Ankle or leg swelling	☐ Blackouts or fainting spells
☐ Blurred vision	☐ Oxygen Use	☐ Stroke symptoms
☐ Double vision	☐ Numbness or weakness of arms or legs	☐ Problem with coordination
☐ Glaucoma	☐ Hip, calf, or thigh pain while walking	☐ Slurred Speech
☐ Cataracts	☐ Indigestion	☐ Rash
☐ Nose Bleeds	☐ Nausea	☐ Change in mole or skin lesion
☐ Dentures	☐ Vomiting	☐ Hearing Aid

PREVENTATIVE SCREENING	
Exam/Test (indicate last date performed)	
☐ Cholesterol (Lipid Panel)	☐ Diabetes (Glucose or HbA1c)
☐ Cardiovascular Disease (EKG)	☐ Osteoporosis (Bone Density)
☐ Prostate Cancer (PSA/Digital Rectal Exam)	☐ Breast Cancer (Mammogram)
☐ Cervical Cancer (Pap Smear)	☐ Colon Cancer (Colonoscopy or FOBT)
☐ Abdominal Aorta Aneurysm (AAA)	☐ Carotid Artery Disease (Ultrasound)
☐ Peripheral Arterial Disease (ABI)	☐ Eye Exam
☐ Kidney Disease (Urine Microalbumin)	☐ Other:

PREFERRED PHARMACY INFORMATION			
LOCAL		**MAIL ORDER**	
Pharmacy Name:		Pharmacy Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Phone:	Fax:	Phone:	Fax:

Gold Canyon Internal Medicine
6788 S. Kings Ranch Road, Suite 1
Gold Canyon, AZ 85118
Phone: 480 626 4999 Fax: 480 304 3239

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: Gold Canyon Internal Medicine

Address: 6788 S. Kings Ranch Road, Suite 1

City: Gold Canyon State: AZ Zip Code: 85118

Fax: 480 304 3239

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

Gold Canyon Internal Medicine

PRACTICE FINANCIAL POLICY

CO-PAYMENTS AND DEDUCTIBLES: These payments must be made either at time of service or at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is considered a violation of contract and fraud. Please help us uphold the law by making your co-payments at each visit and paying deductibles owed at the beginning of the year (including Medicare deductibles and 20% co-insurance).

CLAIM SUBMISSION: As a courtesy to you, we will process and file your insurance claims for services rendered by our Practice. Your insurance company may need additional information from you to process a claim, and it is your responsibility to comply with their request. If your insurance company has not paid your claim within 60 days, the balance becomes your responsibility. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

NON-COVERED SERVICES: Not all services are covered by insurance; they vary from contract to contract. Some insurance companies arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for these services. We will make every effort to ascertain your coverage for our services before treatment and make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

For services that are not covered by insurance, the Practice requires payment of 100% of the total charges at time of service unless prior arrangements have been made.

COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible so that we can update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by a plan that we accept, but you do not have a current insurance card, payment is expected in full at time of service until we can verify your coverage.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full or make payment arrangements with us. Please be aware that if your balance remains unpaid, we reserve the right to refer your account to a collection agency, and your account will become inactive until paid. Account balances turned over to a collection agency will accrue interest at the rate of 16% per annum, or 1.33% per month after 90 days. If your account is turned over to an attorney or pursued legally for collection, you will be responsible for all reasonable attorney's fees, filing fees, and service fees.

All Returned Checks Are Subject to a $30.00 Fee. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Our Practice is committed to providing quality medical care. Our prices are representative of the usual and customary charges for our area.

NO SHOW / CANCELLATION POLICY: A $25.00 fee if you do not show up for a scheduled appointment or cancel the same day as your appointment. Please call us 24 hours in advance if you have to cancel your scheduled appointment.

Thank you for understanding our financial policies. Please let us know if you have any questions or concerns about the above information or any uncertainty regarding your insurance coverage.

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING.

I hereby authorize photocopies of this form to be as valid as the original.

SIGNATURE: ____________________________________ DATE: __________________

Gold Canyon Internal Medicine

6788 S. Kings Ranch Road, Suite 1

Gold Canyon, AZ 85118

HIPAA 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.

This Notice of Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out Treatment. Payment or health Care Operations and for other purposes that are permitted by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition related to health care services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law. At no time will any information of any kind relating to any of our patients be discussed outside of this office unless permitted or required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk when you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also disclose your PHI as necessary to contact you and remind you of your appointment.

We are also permitted to use or disclose your PHI without your written authorization for certain purposes: AS Required By Law, Public Health Activities (e.g. preventing the spread of disease). Health Oversight Activities Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement Purposes, Coroners, Funeral Directors and Organ Donation, Criminal Activity, Military Activity and national Security, Worker's Compensation, Inmates.

Other permitted and required uses and disclosures will be made with your authorization. You may revoke your authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may not receive direct or indirect remuneration in exchange for your PHI without your authorization except in limited circumstances permitted by law. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health related benefits and services. We do not receive any compensation in connection with communications with you about any products or services, except we may communicate with you about prescription drugs or biologics and receive payment from the manufacturer that is reasonable in amount and compensates us for the cost we incurred in connection with that communication. Except for the communications about drugs and biologics, we will obtain your authorization if we will receive direct or indirect payment for communications with you.

We may enter into contract with entities known as Business Associates that provide services to or perform functions on our behalf.

We may disclose PHI to Business Associates once they have agreed in writing to safeguard the PHI. For example, we may disclose PHI to a Business Associate to administer claims. Business Associates are also required by law to protect PHI.

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Your individual rights: The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. We use or maintain electronic health records. You may get that information in electronic format and ask us to send it to a person or organization that you identify. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction on the use or disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, Payment or Health Care Operations. You may also request that that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restrictions to apply. We will consider your request, but in most cases are not legally obligated to agree to those restrictions (e.g., if your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted but you then have the right to use another Health Care Provider. However, we will comply with any restrictions requested if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the PHI pertains solely to a health care item or service that has been paid for out- of-pocket and in full.

You have the right to request and receive confidential communications from us by alternative means or an alternative location.

You have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. Your request for an accounting must be submitted in writing. If we use or maintain an electronic health record for you, you may get a list of the disclosures we have made, if any, of your electronic health record for three years prior to the date of your request. For accountings that do not include disclosures made through an electronic health record, the request may not cover a time period longer than six years from the date of the request.

You have the right to be notified of a breach. You have the right to be notified in the event that one of our Business Associates discovers a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. This notice was published and becomes effective on or before March 1, 2001. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice, you may also request a copy of this notice at any time. You may lodge a complaint to us or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may also file a complaint with us by notifying our HIPAA Compliancy Officer. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of PHI with our HIPAA Compliance Officer in person or by phone at 480 626-1089.

Gold Canyon Internal Medicine

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I acknowledge that I have received a copy of the Notice of Privacy Practices for Gold Canyon Internal Medicine, or have been informed that the Notice is posted in the office and on the practice web site http://www.goldcanyonim.com/

I consent to the use and disclosure of my Protected Health Information (PHI) by Gold Canyon Internal Medicine (GCIM) for purposes of Treatment, Payment and Health Care Operations as described in the Notice. I understand that this consent remains in effect until I rescind it. I have the right to revoke my consent in writing at any time, but any such revocation does not apply to uses or disclosures occurring before the effective date of the revocation. I understand I have the right to request restrictions in how my PHI is used or disclosed to carry out Treatment, Payment and Health Care Operations, but that GCIM is not required to agree with or grant those requests.

To assist us in maintaining confidentiality when calling about your test results or similar PHI, please complete the checklist below indicating where we may contact you regarding such information. Check "N/A" if the contact method is "Not Applicable." In the second column, please **list all contact telephone numbers** (including area codes). In the far right column, be sure to indicate whether we may leave *confidential information* on your respective voice mail or answering machines. Please initial any mistakes or corrections. You may change your preferences at any time.

Finally, HIPAA guidelines prohibit us from leaving a confidential message with your spouse, family member or friend without your written permission. Therefore, you may wish to designate a specific individual (one person only) with whom we may use our discretion to discuss your PHI under limited circumstances. Ideally, that person should be the individual who would assume responsibility for your health care decisions in the event you became incapacitated (i.e. your legal "next of kin"- spouse, parent, eldest child, guardian, etc.).

If you specifically do not want us to share your PHI with anyone else, please also indicate that preference below.

Contact Method	Telephone #	GCIM May Contact Me via						GCIM May Leave a Confidential Message on My						
Home Phone	( )		Yes		No		N/A	**Home Voice Mail**		Yes		No		N/A
Home Fax	( )		Yes		No		N/A	**Work Voice Mail**		Yes		No		N/A
Work Phone	( )		Yes		No		N/A	**Cell Voice Mail**		Yes		No		N/A
Work Fax	( )		Yes		No		N/A	Email is for limited communication only: (e.g. appointment reminders, office updates)						
Cell Phone	( )		Yes		No		N/A							
Email			Yes		No		N/A							
Email address														

I give permission for GCIM to use its discretion in disclosing my PHI to the following individual (limited to one person):

____; _____________________; (_____)_________________

YOUR DESIGNEE'S PRINTED NAME RELATIONSHIP TELEPHONE

___ I do not want my PHI discussed with anyone other than myself.

The GCIM Notice of Privacy Practices is subject to change and revision from time to time. Any such changes will be posted in our office or on our web site as of the effective date.

I hereby acknowledge all of the above:

____

Printed Name

____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

Date: ______/_______/______.

____

RELATIONSHIP OF PERSONAL REPRESENTATIVE TO PATIENT

For Privacy Issues, Please Contact:

Gold Canyon Internal Medicine
Privacy Officer
6788 S. Kings Ranch Road, Ste 1
Gold Canyon AZ 85118
Office Phone: 480 626 4999
Office Fax: 480 304 3239