BluePoint Medical Group

Danka K. Michaels, M.D.
BC Internal Medicine
BC Clinical Biochemistry

Teresa Charniga, M.D.
Family Medicine

Roberto Carillo, RN, APN
Board Certified

Mollie Sutton, RN, APN
Board Certified

PATIENT INFORMATION

LAST NAME: MI: FIRST:

DOB: GENDER: M F MARITAL STATUS: S M D W

HOME PH # CELL PHONE #

STREET APT # CITY STATE ZIP

EMAIL ADDRESS:

SS #:

GUARANTOR

LAST NAME: MI: FIRST:

SS# DOB PHONE #:

STREET CITY STATE ZIP

EMPLOYER PHONE #:

STREET CITY STATE ZIP

EMERGENCY CONTACT

NAME: PHONE CELL PHONE

RELATIONSHIP

NAME PHONE CELL PHONE

RELATIONSHIP

INSURANCE INFORMATION

PRIMARY INSURANCE

ADDRESS: CITY: STATE: ZIP

POLICY HOLDER NAME: DOB

SS# RELATIONSHIP TO PATIENT:

POLICY HOLDER EMPLOYER:

POLICY # GROUP # DATE EFFECTIVE:

SECONDARY INSURANCE

ADDRESS CITY: STATE:

POLICY HOLDER NAME: DOB:

SS# RELATIONSHIP TO PATIENT:

POLICY HOLDER EMPLOYER:

POLICY # GROUP # DATE EFFECTIVE:

The above information is complete and correct. I authorize treatment for the above patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor indicated on the claim. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that be may added to my account in order to recover monies due to the doctor.

PHARMACY CROSS STREETS

PATIENT SIGNATURE DATE GUARANTOR SIGNATURE DATE

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.

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PATIENT MEDICAL HISTORY

NAME _____ DOB _____

ALLERGIES: _____

	SELF/DATE	FAMILY		SELF/DATE	FAMILY
HIGH BLOOD PRESSURE			HEART DISEASE		
VASCULITIS			HEART ATTACK		
LUPUS/CTD			HEART FAILURE		
TB			ANGIOPLASTY		
ASTHMA/EMPHYSEMA			HEART		
LUNG DISEASES			LEG		
BRONCHIECTASIS			KIDNEY		
HEPATITIS			BYPASS SURG.		
CIRRHOSIS			RHEUMATIC FEVER		
GALLSTONES			IRREG. HEART BEAT		
BLOOD DISORDERS			PACEMAKER		
ANEMIA			DEFIBRILLATOR		
THYROID- HYPO			HIGH CHOLESTEROL		
HYPER			BLOOD CLOTS		
THYROID CYSTS			LEG EDEMA		
ARTHRITIS			STROKE/TIA		
BONE DISEASES			ANEURYSM		
SPINAL CORD DISORDERS			DIABETES		
KIDNEY DISEASES			CANCER		
KIDNEY STONES			EYE DISEASES		
GOUT			EAR DISEASES		
ULCERS			SKIN DISEASES		
GERD			MUSCLE DISEASES		
HIATAL HERNIA			MIGRAINE HEADACHES		
H.PYLORI			SLEEP DISORDERS		
PANCREATITIS			PARKINSON'S		
HEMORRHOIDS			MOOD DISORDERS		
COLON POLYPS			NERVE DISORDERS		
COLITIS			SEIZURES/EPILEPSY		

3320 N. Buffalo Drive, st. 106
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SURGERIES

	DATE OR AGE		DATE OR AGE
APPENDIX		HERNIA	
TONSILS		JOINT REPLACEMENT	
GALLBLADDER		ARTHROSCOPY	
HYSTERECTOMY		AORTA	
OVARIES		SINUSES	
HEMORRHOIDS		BLADDER	
STOMACH		KIDNEY	
BOWELS/RECTUM		LAPAROSCOPY	
OTHERS			

OB-GYN HISTORY:

PREGNANCY: MISCARRIAGES?: ABORTIONS?: LIVE CHILDBIRTHS: LAST PAP:

LAST MAMMOGRAM: STD? AGE @ MENOPAUSE

BIOPSY? LEEP? FIBROIDS? OVARIAN CYSTS? ENDOMETRIOSIS?

PROSTATE HEALTH :

LAST RECTAL: LAST PSA: PROSTATE SURG?

HAVE YOU EVER ENGAGED IN:

SMOKING? Y/ N HOW LONG? HOW MUCH? QUIT?

ALCOHOL? Y/ N HOW LONG? HOW MUCH? QUIT?

ILLEGAL DRUGS? Y / N WHAT KIND? SMOKED? INHAL?

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PATIENT HISTORY - CONT.

OCCUPATIONAL HISTORY: PROFESSION: _____

EXPOSURES:	TOXINS	FUMES	ASBESTOS	TB
	DUST	RADIATION	OTHER	

RELIGIOUS PREFERENCES RELEVANT TO HEALTH: _____

CURRENT MEDICATIONS: INCL. OVER THE COUNTER Rx - DOSE AND FREQUENCY:

1	8	
2	9	
3	10	
4	11	
5	12	
6	13	
7	14	

VACCINATIONS:

HEPATITIS	MMR	SMALL POX
TETANUS	PNEUMOVAX	SHINGLES
DTP	INFLUENZA	OTHER

DO YOU REQUIRE SPECIAL DIET? _____

DO YOU USE: WALKER WHEELCHAIR CANE OXYGEN

DO YOU HAVE A LIVING WILL? _____

PREVIOUS PHYSICIANS:
NAME, ADDRESS, PHONE & FAX #

1. _____
2. _____
3. _____
4. _____
5. _____

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PREVENTATIVE MEDICINE

Patient Name: DOB:

PREVENTATIVE MEASURE	DATE
FLU SHOT	
PNEUMOVAX	
ZOSTAVAX	
CHEST X-RAY	
PAP	
MAMMOGRAM	
DRE	
PSA	
EKG	
ECHO	
STRESS TEST	
ANGIOGRAM	
EGD	
COLONOSCOPY	
DIABETIC EYE EXAM	
PODIATRY	
VISION _____ _____	
DENTAL	
DEXA SCAN _____	
MICROALBUMIN	

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Last Name'_____First Name'_____Middle Initial'_____

Social Security #_____DOB_____M/F____Race'_____

Patient Privacy Directive

In our efforts to comply with Health Insurance Portability and Accountability Act (HIPPAAA), we need to be certain that we guard your privacy according to your wishes when it comes to you family, friends and co-workers.

*Please provide us with the phone number(s) that we or an automated service may leave messages regarding appts.'

_____ _____

*Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or test results:

_____ _____

*Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

_____ _____

_____ _____

•Please provide us with the name(s) and phone number(s) that we may talk to regarding your treatments and/or test results.

_____ _____

_____ _____

*Please provide us with the name(s) and phone number(s) that we may talk to regarding your billing:

_____ _____

_____

*Please provide an email address that this office may communicate health information to you:

Please provide a cell phone number that we may text health information to you-

_____

*Please provide us with the name and phone number of your emergency contacts '

_____ _____

*Please indicate if we can mail lab and other results to the address indicated in your file: _____Yes _____No

You must inform us in writing of any changes in your directives.

I acknowledge that everything above is accurate.

_____ _____ _____

Signature *printed name* *date*

_____ _____

Relationship if Patient Representative *Physician Office Representative*

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outline in the notice.

I have received a copy of the "Notice of Privacy Practices"

_____

Name of Patient (PRINT)

_____ _____

Patient Signature Date

_____

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following '

May we leave messages concerning your appointments with a co—worker, receptionist or secretary that regularly answers your calls? Yes No N/A

May we leave messages on a voice mail at work? Yes No N/A

May we discuss your appts./private medical information with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your appts./private medical information with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your appts/private medical information with your children? Yes No N/A

You must inform us in writing if you wish to change the manner in which this office communicates with you.

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Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concern about our payment policies, please do not hesitate to ask for our Billing Department (869-6190 ext: 6).
You must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. Our relationship is with you, not your insurance company.

2. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire with the staff prior to treatment. Please be aware that not all services are a covered benefit in all insurance policies. You are responsible for knowing, per your insurance plan on what services are or are not covered. Fees for these services, along with any unpaid deductible and co-payment are due prior to the time of treatment. You are responsible for these amounts.

3. You are responsible for knowing your insurance benefits. Does your insurance require a referral? What facilities participate in your plan? If we can be of assistance, please let us know. We are sure we can answer most questions regarding your insurance.

4. We will send you a statement monthly to keep you informed on the status of your account until the account is paid in full or placed in collection.

5. We will bill the insurance information you provided to us as a courtesy, but you are still ultimately responsible for payment of any services you receive. We will also follow up on your claim. We will be checking with your carrier once verbally and once in writing. If, however, your insurance does not respond to us within 60 days of claim submission, the amount will become your responsibility and you will have to follow up with your carrier for payment of the claim.

6. If your medical claim has not been paid by your insurance company, and you have contacted them with no results, there is recourse for you. The Nevada Department of Business and Industry has established an insurance division to receive questions, complaints, and comments from the consumers in Nevada concerning healthcare plans. Their address is 555 E. Washington Ave., Las Vegas, NV 89101 and phone number is: (702) 486-4000.

7. If you are a Medicare beneficiary by Federal Law we are required to collect 20% of the "Medicare Assignment" portion which the Federal Government does not pay. Medicare will only pay 80% of the assigned amount after your deductible has been paid. Again, if you have a financial problem or questions, please ask for our Office Manager or Billing Department.

8. If it becomes necessary that your account must be turned over to collection you will be notified first. You are responsible for all collection and legal fees.

9. **Returned checks** are subject to a **$25.00** fee. ____

10. There is a **no show/cancelling without 24 hr. notice** fee of $25.00/office visit, $75.00/ultrasound, and $75.00/nerve conduction study. _____

Please be aware that we do understand any temporary problems one may have at the time of the visit. We encourage you to make us aware of this prior to the treatment, so we can assist you in any way regarding your balance. **OUR MAIN CONCERN ARE OUR PATIENTS WELL BEING.**

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

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Purpose of this Form:

BLUEPOINT MEDICAL GROUP offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer
and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) the secure message must reach the correct email address, and
2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address**. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone.

If there is information that you don't want transmitted via online communication, please inform your practice.

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Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

PATIENT'S PRINTED NAME

PATIENT'S E-MAIL ADDRESS

PATIENT'S SIGNATURE

DATE

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the following physician/facility to release my protected health information:

Previous Physician/ Facility: _____

Address: _____

_____

Phone: _____ **Fax:** _____

Information to be disclosed (circle all that applies):

COMPLETE HEALTH RECORDS HOSPITAL RECORDS

PROGRESS NOTES ONLY RADIOLOGY REPORTS & LABORATORY TESTS

OTHER (PLEASE SPECIFY) _____

_____

I UNDERSTAND THAT THIS WILL INCLUDE INFORMATION RELATING TO:

- Human Immunodeficiency Virus (HIV) infection
- Behavioral Health services/psychiatric care
- Treatment for alcohol and/ or drug abuse

Please release the above noted medical records to:

BluePoint Medical Group
3320 N. Buffalo Dr., st. 106
Las Vegas, NV 89129
Ph: (702) 869-6190 Fax: (702) 869-6199

I certify that I have read and upon request will receive a copy of this Authorization. I agree to this release of health information as described herein.

PRINT PATIENT'S NAME	SIGNATURE	DATE

Print name of legal representative	Signature of legal representative	Date

DOB: _____ [redacted] _____ Contact#: _____

PURSUANT TO N.R.S. 629.061.1. THERE WILL BE A FEE OF $0.60 FOR ALL RECORDS REQUESTED FOR PATIENT USE.

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DANKA K.MICHAELS, M.D. A PROFESSIONAL CORPORATION

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Atl0f 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 (IIHI). In convicting our business, we will create records regarding you and the treatment and services we provide to you. We are required by lav to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with 6ii notice of our legal duties and the privacy practices that we maintain in our practice concerning your IU-II. By federal and state tae, 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 yourIIHI
- Your privacy rights in yourIIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to nil records containing your IIHI that are created or retained by Our practice. We reserve the right to revise or 9mend 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: DANKA K. MICHAELS, M.D., A PROFESSIONAL CORPORATION 3320 N. Buffalo Dr. st. 106 Las Vegas, NV 89129, phone # 702 869-6190**

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

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

1. **Treatment**. Our practice may use your IIHI 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 IIHI in order to write a prescription for you, or we might disclose your IIHI 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 IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. Por 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 di•c1ose your **IIHI to obtain payment** from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclosebyour IIHI 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 IIHI 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 IIHI 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 IIHI to other health care providers and entities to assist in their health care operations.
4. **Disclosures Required By Law**. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

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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 HH[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 e 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 clan 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 IIHI to a health oversight agency for activities authority 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 IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI 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 part' has requested.
4. **Law Enforcement**. We may release IIHI 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. **Serious Threats to Health or Safety**. Our practice may use and disclose your IIHI when necessary to reduce or privet 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.
6. **Military**. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
7. **National Security**. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law\., We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates**. Our practice may disclose your IIHI 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.
9. **Workers' Compensation**. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI 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: DANKA K MICHAELS, M.D., A PROFESSIONAL CORPORATION 3330 N. Buffalo Dr. st. 106 Las Vass, .V 89139, phone # 702/ 869-6190 specifying the requested the requested method of contact or the location where you wish to be contacted. Our practice will accommodate reasonable request. 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 IIHI for treatment payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI 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 IIHI, you must make your request in writing to: DANKA K. MICHAELS, M.D., A PROFESSIONAL CORPORATION 3320 N. Buffalo Dr. st. 106 Las Vegas, NV 89129, phone # 702f 869-6190

Your request must describe in a cream and concise fashion:

(a) the in formation you wi3h restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits toapply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI 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: **DANKA K. MICHAELS, M.D., A PROFESSIONAL CORPORATION 3320 N. Buffalo Dr. st. 106 Las Vegas, NV 89129 phone # 702/ 869-6190** in order to inspect and/or obtain a copy of your IIHI. 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 heath information if you believe it is incorrect or incomplete, and yet 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 contact: **DANKA K. MICHAELS, M.D., A PROFESSIONAL CORPORATION 3320 N. Buffalo Dr, #106 Las Vegas, NV 89139, phone # 702/ 869-6190.** 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 IIHI kept by or for the practice; (c) not part of the IIHI 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 disclousers" An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non- operations purposes. Use of your IIHI 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: **DANKA K. MICHAELS, M.D., A PROFESSIONAL CORPORATION 3320 N. Buffalo Dr., st. 106 Las Vegas, NV 89129 phone # 702 869-6190**. 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, 2012. 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. Yin may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice: **DANKA K. MICHAELS, M.D., A PROFESSIONAL CORPORATION 3320 N. Buffalo Dr. st. 106 Las Vegas, NV 89129, phone # 702 869-6190.**

7. Right to. File s 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 compliant with our practice contact: **DANKA K. MICHAELS, M.D., A PROFESSIONAL CORPORATION 3320 N. Buffalo Dr. st. 106 Las Vegas, NV 89129, phone # 702 869-6190.** All complaints must be submitted in writing. **You will not be penalized for filing a compliant.**

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 IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.