



Mona Bhalla, ND, LLC
NATUROPATHIC PHYSICIAN

Mona Bhalla, ND, LLC
1221 SE Madison St.
Portland, OR 97214
503-445-7767
FAX: 503-459-4221

Patient's name **Please print** _____
Last Middle First

Natural medicine healthcare is possible only when the physician completely understands the patient's physical, mental, and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything about which you have questions.

<p>Address _____ <i>Street or POB</i></p> <p>_____</p> <p><i>City, state, zip</i></p> <p>Phone _____</p> <p><i>Home Cell</i></p> <p>_____</p> <p><i>Work (with extension)</i></p> <p>Email _____</p> <p>SSN _____</p> <p>Date of birth _____ Age ____ <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>Emergency contact _____</p> <p><i>Name</i></p> <p>_____</p> <p><i>Address</i></p> <p>_____</p> <p><i>Phone</i></p> <p>_____</p> <p><i>Relationship</i></p> <p>Occupation _____</p> <p>How many children do you have? _____</p> <p>Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____</p> <p>With whom do you live? <input type="checkbox"/> Spouse <input type="checkbox"/> Friends <input type="checkbox"/> Parents <input type="checkbox"/> Alone <input type="checkbox"/> Children <input type="checkbox"/> _____</p> <p>Who can I thank for the referral? _____</p> <p>_____</p>	<p>When did you last go to a doctor's office, medical clinic, or hospital? What was the reason?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>What are your major health concerns?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Signature _____
Responsible party if patient is a minor

Please print name _____ Date _____

HOSPITALIZATION AND SURGERY

What hospitalization or surgeries have you had?

X-RAYS AND SPECIAL STUDIES

What diagnostic imaging studies have you had?

- Electrocardiogram Electroencephalogram
- Xrays Mammogram
- CT scan MRI
- Bone density scan
- Other _____

MEDICATIONS OR SUPPLEMENTS

List medications/supplements you currently take.

Please check (✓) the box for any of the following you currently take:

- Pain relievers (aspirin/Tylenol)
- Diet pills/appetite suppressants
- Cortisone (cream or pills)
- Thyroid medication
- Sleeping pills
- Antacids (Rolaids/Tums)
- Laxatives
- Tranquilizers

ALLERGIES

Do you have allergies to food, drugs, or other allergens in your environment (ie - cats, mold, dust)? If yes, please explain. No Yes

IMMUNIZATIONS

What immunizations have you had? Please place a "?" on the line if you do not know.

- ___ Diphtheria ___ Measles/mumps/rubella
- ___ Polio ___ Pertussis
- ___ Tetanus shot (not antitoxin)
- ___ Other _____

CHILDHOOD ILLNESSES

Have you had the following illnesses? Yes No

- | | | |
|-----------------|--------------------------|--------------------------|
| Scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Diphtheria | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Mumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Measles | <input type="checkbox"/> | <input type="checkbox"/> |
| German measles | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | |

SELF AND FAMILY HISTORY

Father

- Health Good Poor
- Age (at death) _____
- Cause of death _____
- _____

Mother

- Health Good Poor
- Age (at death) _____
- Cause of death _____
- _____

SELF AND FAMILY HISTORY (continued)

Please check (✓) the box for any of the following that you or family members have experienced.

Cancer	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Heart disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
High blood pressure	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Epilepsy	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Mental illness	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Asthma	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Hayfever, hives	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Anemia	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Kidney disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Liver disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Gallbladder disease	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Ulcer	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Tuberculosis	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Goiter	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Arthritis	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Heart murmur	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> self	<input type="checkbox"/> father	<input type="checkbox"/> mother	<input type="checkbox"/> sister	<input type="checkbox"/> brother	<input type="checkbox"/> children	<input type="checkbox"/> _____

REVIEW OF SYSTEMS: Please circle the response that applies:

Y = a condition you have now

P = a condition you have had in the past

N = a condition you have never had

GENERAL

Weight _____ Weight 1 year ago _____
 Maximum weight _____
 When _____ Height _____
 Fatigue Y P N

EARS

Impaired hearing Y P N
 Ringing Y P N
 Earache Y P N
 Dizziness Y P N

RESPIRATORY

Cough Y P N
 Sputum Y P N
 Spitting up blood Y P N
 Wheezing Y P N
 Asthma Y P N
 Bronchitis Y P N

SKIN

Rashes Y P N
 Eczema, hives Y P N
 Acne, boils Y P N
 Itching Y P N
 Color change Y P N
 Lumps Y P N
 Night sweats Y P N

NOSE AND SINUSES

Frequent colds Y P N
 Nose bleeds Y P N
 Stuffiness Y P N
 Hay fever Y P N
 Sinus problems Y P N

Pneumonia Y P N
 Pleurisy Y P N
 Emphysema Y P N
 Difficulty breathing Y P N
 Pain on breathing Y P N
 Shortness of breath Y P N
 At night Y P N
 Lying down Y P N

HEAD

Headache Y P N
 Head injury Y P N

Frequent sore throat Y P N
 Sore tongue Y P N
 Gum problems Y P N
 Hoarseness Y P N
 Dental cavities Y P N

CARDIOVASCULAR

Heart disease Y P N
 Angina Y P N
 High blood pressure Y P N
 Murmurs Y P N
 Rheumatic fever Y P N
 Chest pain Y P N
 Swelling in ankles Y P N
 Palpitations, fluttering Y P N

EYES

Impaired vision Y P N
 Glasses or contacts Y P N
 Eye pain Y P N
 Tearing or dryness Y P N
 Double vision Y P N
 Glaucoma Y P N
 Cataracts Y P N

NECK

Lumps Y P N
 Swollen glands Y P N
 Goiter Y P N
 Pain or stiffness Y P N

REVIEW OF SYSTEMS (continued): Please circle the response that applies:

Y = a condition you have now

P = a condition you have had in the past

N = a condition you have never had

GASTROENTESTINAL

Trouble swallowing Y P N
Heartburn Y P N
Change in thirst Y P N
Change in appetite Y P N
Nausea Y P N
Vomiting Y P N
Vomiting blood Y P N
Bowel movements
 How often? _____
 Is this a change? _____

Blood in stool Y P N
Belching or passing gas Y P N
Jaundice (yellow skin) Y P N
Liver disease Y P N
Hemorrhoids Y P N
URINARY
Pain on urination Y P N
Increased frequency Y P N
Frequency at night Y P N
Inability to hold urine Y P N
Frequent infections Y P N
Kidney stones Y P N

FEMALE REPRODUCTIVE

Age menses began? _____
Average number of days? _____
Length in cycle? _____
Bleeding between periods Y P N
Are cycles regular? Y P N
Pain during intercourse Y P N
Painful menses Y P N
Excessive flow Y P N
Birth control? Yes No
What type? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Difficulty conceiving Yes No
Menopausal symptoms Y P N

Are you sexually active? Yes No
Sexual difficulties Y P N
Venereal disease Y P N
Sexual preference Heterosexual
 Bisexual
 Homosexual
Do you self-exam? Y P N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

MALE REPRODUCTIVE

Hernia Y P N
Testicular masses Y P N
Testicular pain Y P N
Are you sexually active? Yes No
Sexual difficulties Y P N
Venereal disease Y P N
Discharge or sores Y P N
Sexual preference Heterosexual
 Bisexual
 Homosexual

MUSCULOSKELETAL

Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms or cramps Y P N
Weakness Y P N
PERIPHERAL VASCULAR
Deep leg pain Y P N
Cold hands/feet Y P N
Varicose veins Y P N
Thrombophlebitis Y P N

NEUROLOGIC

Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle weakness Y P N
Numbness or tingling Y P N
Loss of memory Y P N
EMOTIONAL
Depression Y P N
Mood swings Y P N
Anxiety or nervousness Y P N
Tension Y P N
ENDOCRINE
Hypothyroid Y P N
Heat or cold intolerance Y P N
Excessive thirst Y P N
Excessive hunger Y P N

BLOOD

Anemia Y P N
Easy bleeding or bruising Y P N

HABITS

What are our main interests and hobbies?

Do you exercise? Yes No
How many days per week? _____

What type of exercise do you do?

Eat three meals daily? Yes No
Awaken rested? Yes No
Sleep well? Yes No
Avg 7–8 hours' sleep? Yes No
Enjoy your work? Yes No
Spend time outside? Yes No
Take vacations? Yes No
Watch television? Yes No
How many hours per day? _____

Read? Yes No
How many hours per day? _____
Use recreational drugs? Yes No
Use tobacco? Yes No
Drink alcohol? Yes No
Treated for alcoholism? Yes No
Treated for drug dependence? Yes No

I certify that the information I have supplied is correct and accurate to the best of my knowledge.

Name _____

Date _____



Mona Bhalla, ND, LLC
1221 SE Madison St.
Portland, Oregon 97214

Insurance information, consent to treat, and payment policy for patients of Mona Bhalla, ND, LLC

Name _____ Telephone _____
Address _____ Date of first visit to clinic _____
_____ SSN _____
Date of birth _____

Insurance coverage

Name of insured _____ SSN of insured _____
Date of birth of insured _____ Employer _____
Address and telephone of employer _____

Insured relationship to patient self spouse child partner
 other _____ Insured is male female

Insurance company _____ Address _____

Telephone _____ Adjuster _____
Group or plan number _____ Claim number _____
(Workers comp)
Emergency telephone number _____

Consent form and agreement

Naturopathic therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of Mona Bhalla, ND, LLC, to inform patients about them. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury or bruising, dizziness, or temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform patients of procedures being performed and the risks and alternative treatments available. If your physician does not explain these risks to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

Signature of patient

Date

Agreement to payment policy of Mona Bhalla, ND, LLC

By signing below, I understand that full payment for all services and products I receive from Mona Bhalla, ND, LLC, is required at the time of service. Any failure to make an appointment cancellation with Mona Bhalla, ND, LLC within 24 hours of the scheduled time, unless due to an emergency, is subject to a \$60 charge to the patient. Further, I understand that Mona Bhalla, ND, LLC, may submit my bill to my insurance carrier on my behalf, if I so request, and that Mona Bhalla, ND, LLC, cannot be held responsible for either the amount of reimbursement I receive or any delay between the time of submission and the time of reimbursement.

Signature of patient

Mona Bhalla, ND, LLC
1221 SE Madison St.
Portland, OR 97214

Consent for Purposes of Treatment and Healthcare Operations for Patients of Mona Bhalla, ND, LLC.

Naturopathic Medical Consent: I consent to the use or disclosure of my protected health information by Mona Bhalla, ND, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Mona Bhalla, ND, LLC. I understand that diagnosis or treatment of me by my physician at Mona Bhalla, ND, LLC may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mona Bhalla, ND, LLC is not required to agree to the restrictions that I may request. However, if Mona Bhalla, ND, LLC agrees to the restrictions that I request, the restriction is binding on Mona Bhalla, ND, LLC and my physician at Mona Bhalla, ND, LLC.

I have the right to revoke this consent in writing, at any time, except to the extent that my physician at Mona Bhalla, ND or Mona Bhalla, ND, LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Mona Bhalla, ND, LLC's Notice of Privacy Practices prior to signing this document. Mona Bhalla, ND, LLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Mona Bhalla, ND, LLC. This Notice of Privacy Practices also describes my rights and Mona Bhalla, ND, LLC's duties with respect to my protected health information.

Mona Bhalla, ND, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me by mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority



Notice of Patient Privacy Policy

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 describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your right to access and control your protected health information. “**Protected Health Information**” (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our clinic, you are implying consent to the use and disclosure of your protected health information by your provider, our office staff, and others outside of our clinic that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operations of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

· **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your PHI, as necessary, to another physician who may be treating you. Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your PHI to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your healthcare plan may undertake before it approves or pays for the health care services we recommend for you. This may include making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant PHI be disclosed to the health plan to obtain approval for those services.
- **Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities, and training of medical assisting externs and chiropractic students.

For example, we may disclose your protected health information to interns, externs, or students that see patients at our office. In addition, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or their assistants may be recorded to assist in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We do have open therapy/adjusting areas.

We will share your protected health information with third party “business associates” that will perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure, we will have a written contract with that business associate that contains terms that will protect the privacy of your PHI.

We may use your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other internal marketing activities. We may also send you information about products or services that we believe may be beneficial to you. You may contact either of our Privacy Officers to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below.

- Disclosures of psychotherapy notes
- Uses and disclosures of Protected Health Information for marketing purposes;
- Disclosures that constitute a scale of Protected Health Information;
- Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your PHI, you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying, a family member, personal representative, or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your PHI to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Abuse or Neglect:** We may disclose your PHI to a public authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful purposes.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as the result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
- **Workers' Compensation:** We may disclose your PHI, as authorized, to comply with worker's compensation laws and other similar legally-established programs.
- **Required Uses and Disclosures:** Under the law, we must make disclosures to you 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 et. seq.

B. Your Rights

The following is a statement of your rights with respect to your PHI and brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access can be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officers if you have any questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for the health care delivered by our office.* You may also request that any part of your protected health information 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 restriction requested and to whom you want the restriction to apply. *You may also opt out of fundraising communications in which our office participates.*

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor. You may request a restriction by presenting your request, in writing, to the staff members identified as "Privacy Officer" at the top of this form. The Privacy Officers will provide you with a "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not be requesting an explanation from you as to the basis for the request. Please make this request in writing.
- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for this 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 with a copy of any such rebuttal. Please contact either of our Privacy Officers if you have questions about amending your medical record.
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003.
- **You have the right to be notified by our office of any breach of your protected health information.**
- **Certain treatments may be performed in a common therapy area and/or you may find yourself within public areas within the clinic at times, but private rooms are always available, upon request, for discussing your private health information.**

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 electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. To file a complaint, you may go to: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf>. Our office can also provide you with a written form in which to file your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 12, 2017.



Consent to Use Protected Health Information

Acknowledgement for Consent and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Dr. Mona Bhalla ND, LLC or may be disclosed to others purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

Requesting a Restriction on the Use or Disclosure of your Protected Health Information

- ❖ You may request a restriction on the use or disclosure of your Protected Health Information.
- ❖ This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- ❖ If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request.

Revocation of Consent

You may revoke this consent of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Date