



Dr. Justin Morse, ND

scheduling@absolutehmc.net

4765 Village Plaza Loop, Suite 201

Eugene, OR 97401

PH: (541) 636-3100 * FAX: (541) 636-3913

Health Intake Forms

Absolute Health Medical Center provides facilities and staff to assist you, however, to provide you the most successful health care it is important to have a complete and thorough understanding of your physical and mental history. Please complete the following questionnaire as thoroughly as possible. Except in emergencies, treatment is not performed until you have had an opportunity to receive information about your treatment and to give your informed consent.

PLEASE ANSWER ALL QUESTIONS (Front & Back)

Name: _____ Date: _____

Legal Name: _____ Age: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ Phone (C): _____

Email: _____

Gender: Female Male Marital Status: Married Divorced Single Widowed Other

Education: _____ Occupation: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____

Address: _____

How did you hear about us? _____

Are you currently receiving health care? Yes / No If No, date of last exam? _____

Physician Name: _____ Location: _____

Preferred Pharmacy: _____ Location: _____

Why are you here today? Please list primary health complaints

1. _____

2. _____

3. _____

Are you willing to make the **NECESSARY** changes **NEEDED** in your life to get better? Yes / No

Do you currently have any contagious diseases? Yes / No What? _____

MEDICATIONS & SUPPLEMENTS

Please list **any & all** prescription medications, over the counter medications, vitamins and/or other supplements you are taking. Include frequency and dosage (add additional paper if necessary)

Medication	Dosage	Frequency	For?
Supplements	Dosage	Frequency	For?

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Glasses of Water Daily? _____ **Caffeine Amount?** _____ **# Meals per Day?** _____

Alcohol Use? Yes / No **Frequency?** _____ **Type?** _____

HISTORY & HABITS

Alcohol Use? Yes / No **Frequency?** _____ **Type?** _____

Tobacco Use? Yes / No **Frequency?** _____ **Type?** _____

TCH/CBD Use? Yes / No **Frequency?** _____ **Type?** _____

Treated for Drug or Alcohol Dependence? **Yes / No** **When:** _____

SLEEP & ENERGY

Sleep Well	Yes / No	Daily Energy Level (1 low - 10 high): 1 2 3 4 5 6 7 8 9 10
Fall Asleep Easily	Yes / No	Average Hours of Sleep Nightly? _____
Wake Frequently	Yes / No	Time of Day Energy Level is Best? _____
Awake Rested	Yes / No	
Exercise #Days/wk: 1 2 3 4 5 6 7 0		Type of Exercise: _____

HOSPITALIZATIONS & SURGERIES

For: _____ **Year:** _____

For: _____ **Year:** _____

For: _____ **Year:** _____

For: _____ **Year:** _____

X-rays, CAT scans, or other studies you've had:

For: _____ **Year:** _____

For: _____ **Year:** _____

For: _____ **Year:** _____

For: _____ **Year:** _____

For: _____ **Year:** _____

How does your lack of health affect you? _____

What do you think is happening? _____

Why? _____

What do you feel needs to happen for you to get better? _____

What do you enjoy most in your life? _____

Do you enjoy your work / job? _____

Is there any additional information you'd like to add? _____

GENERAL

Height _____ Weight _____ Weight 1 yr. ago _____ Max Weight _____ When _____

FAMILY HISTORY	Mother	Father	Other (Please specify)
Diabetes (Type 1 or 2?)			
Alzheimer's			
Fibromyalgia			
Heart Attack / Disease			
Thyroid Conditions			
Depression			
Anxiety			
Addictions (what kind?)			
Cancer (what kind?)			
Other Medical Conditions (specify)			

REVIEW OF SYMPTOMS

C = Current Condition **P** = Past Condition **N** = Never

ENDOCRINE					
Hypothyroid	C P N	Slow Wound Healing	C P N	Excessive Thirst	C P N
Hot and/or Cold Intolerance	C P N	Hypoglycemia	C P N	Excessive Hunger	C P N
Cold Hands	C P N	Diabetes (Type 1 or 2)	C P N	Seasonal Depression	C P N
Cold Feet	C P N	Fatigue	C P N	Eyebrow Loss	C P N
Hot flashes during day (not sweat)	C P N	Hair Thinning	C P N	Painful Intercourse	C P N
Decreased Sex Drive	C P N	Voice Hoarseness	C P N	Increase in Moodiness	C P N
Inability to Sweat	C P N	Decrease in Appetite	C P N	Abnormal Hair Growth	C P N
Loss of Muscle Mass & Strength	C P N	Easily Stressed	C P N		
History of Low Body Temps	C P N	Night Sweats	C P N		
MALE REPRODUCTION					
Hernias	C P N	Testicular Pain	C P N	Testicular Masses	C P N
Prostate Disease	C P N	Venereal Disease	C P N	Chlamydia	C P N
Discharge or Sores	C P N	Gonorrhea	C P N	Condylomia	C P N
Premature Ejaculation	C P N	Herpes	C P N	Syphilis	C P N
Sexually Active	Yes / No	Impotence	C P N	Elevated PSA	C P N
Prostate Enlargement	C P N	Testicular or Prostate Cancer			C P N
Waking Morning Erection	Yes / No	Difficulty Getting an Erection			Yes / No
Difficulty Achieving Orgasm	Yes / No	Difficulty Maintaining an Erection			Yes / No
Difficulty Maintaining Erection During Sex If You Are Lying On Your Back					Yes / No
Sexual Orientation		Birth Control Method			

C = Current Condition P = Past Condition N = Never

FEMALE REPRODUCTION					
Age of First Menses: _____		Date of Last Menses: _____		Length of Cycle: _____	
In Menopause? Yes / NO		Last Mammogram: _____		Last Pap: _____ Any Abnormal? _____	
Duration of Menses: _____		Birth Control? Yes / No What Type? _____			
Number of Pregnancies: _____		Number of Live Births: _____		Number of Miscarriages: _____	
Number of Abortions: _____		Headaches Just Before Monthly Menses? Yes / No			
PMS? Yes / No Symptoms: _____		Average Time Between Cycles? _____			
Painful Menses	C P N	Regular Cycles	C P N	Clotting	C P N
Heavy or Excessive Flow	C P N	Discharge	C P N	Endometriosis	C P N
Bleeding Between Cycles	C P N	Vaginal Dryness	C P N	Ovarian Cysts	C P N
Difficulty Conceiving	C P N	Cervical Dysplasia	C P N	Sexual Difficulties	C P N
Are You Sexually Active	Yes / No	Herpes	C P N	Breast Lumps	C P N
Do You Do Breast Self Exams	Yes / No	Nipple Discharge	C P N	Breast Pain/Tenderness	C P N
History of Fibrocystic Breasts	Yes / No	Excessive Vaginal Fluid Yes / NO			
Sexual Orientation _____		Birth Control Method _____			
MENTAL / EMOTIONAL					
Treated for Emotional Problems	C P N	Mood Swings	C P N	Depression	C P N
Memory Problems	C P N	Tension	C P N	Poor Concentration	C P N
Psychiatric Disorder	C P N	Mental Illness	C P N	Anxiety	C P N
Considered/Attempted Suicide	C P N	Nervousness	C P N	History of Abuse	C P N
MUSCULOSKELETAL					
Joint Pain or Stiffness	C P N	Broken Bones	C P N	Arthritis	C P N
Muscle Spasms or Cramps	C P N	Weakness	C P N	Sciatica	C P N
Where do you most often hurt? _____				Hours per day _____	
What alleviates your pain? _____			What worsens it? _____		
Pain in these joints?					
Ankles/Foot Yes / No Why? _____		Knees Yes / No Why? _____			
Hips Yes / No Why? _____		Low Back Yes / No Why? _____			
Neck Yes / No Why? _____		Shoulder(s) Yes / No Why? _____			
Elbow(s) Yes / No Why? _____		Hands Yes / No Why? _____			
Other? _____					
GASTROINTESTINAL					
Trouble Swallowing	C P N	Heartburn	C P N	Nausea	C P N
Change in Thirst	C P N	Vomiting	C P N	Vomiting Blood	C P N
Change in Appetite	C P N	Blood in Stool	C P N	Pain or Cramps	C P N
Belching or Passing Gas	C P N	Black Stools	C P N	Jaundice (yellow skin)	C P N
Liver Disease	C P N	Constipation	C P N	Diarrhea	C P N
Gall Bladder Disease	C P N	Ulcer	C P N	Hemorrhoids	C P N
Do you see food in stool	Yes / No	Hard Stool	C P N	Mucus in Stool	C P N
Bowel Movements: How Often? _____ Is this a change? Yes / No					

C = Current Condition **P** = Past Condition **N** = Never

IMMUNE					
Chronically Swollen Glands	Yes / No	Do you get sick Often	Yes / No	Chronic Infections	C P N
IMMUNIZATIONS					
Measles/Mumps/Rubella	Yes / No	Polio	Yes / No	Pertussis	Yes / No
Tetanus Shot	Yes / No	Diphtheria	Yes / No		
NEUROLOGICAL					
Seizures	C P N	Vertigo or Dizziness	C P N	Paralysis	C P N
Muscle Weakness	C P N	Loss of Memory	C P N	Loss of Balance	C P N
Numbness or Tingling	C P N				
SKIN					
Rashes	C P N	Acne, Boils	C P N	Eczema, Hives	C P N
Abnormal Hair Growth	C P N	Color Changes	C P N	Itching	C P N
Lumps	C P N	Dry Skin	C P N		
HEAD					
Headaches	C P N	Head Injury	C P N	Migraines	C P N
Jaw/TMJ Problems	C P N				
EYES					
Spots in Eyes	C P N	Cataracts	C P N	Impaired Vision	C P N
Glasses or Contacts	C P N	Blurriness	C P N	Eye Pain/Strain	C P N
Color Blindness	C P N	Excessive Tearing	C P N	Double Vision	C P N
Glaucoma	C P N	Dryness	C P N	Improved Vision	C P N
EARS					
Impaired Hearing	C P N	Ringings	C P N	Earaches	C P N
Excessive Ear Wax	C P N				
NOSE AND SINUSES					
Frequent Colds	C P N	Nose Bleeds	C P N	Stiffness	C P N
Hay fever	C P N	Sinus Problems	C P N	Loss of Smell	C P N
MOUTH AND THROAT					
Frequent Sore Throat	C P N	Teeth Grinding	C P N	Gum Problems	C P N
Dental Cavities	C P N	Copious Saliva	C P N	Hoarseness	C P N
Jaw Clicks	C P N	Regular Dental Visits (every 6 months)			Yes / No
NECK					
Lumps	C P N	Swollen Glands	C P N	Goiter (Under Chin)	C P N

RESPIRATORY					
Cough	C P N	Sputum	C P N	Wheezing	C P N
Spitting up Blood	C P N	Asthma	C P N	Pneumonia	C P N
Emphysema	C P N	Pain on Breathing	C P N	Tuberculosis	C P N
Bronchitis	C P N	Pleurisy	C P N	Difficulty Breathing	C P N
Shortness of Breath	C P N	Shortness of Breath Lying Down and/or at Night			C P N
CARDIOVASCULAR					
Heart Disease	C P N	Angina	C P N	Murmurs	C P N
High Blood Pressure	C P N	Blood Clots	C P N	Fainting	C P N
Low Blood Pressure		Rheumatic Fever	C P N	Swelling in Ankles	C P N
Phlebitis	C P N	Palpitations/Fluttering	C P N	Chest Pain	C P N
Dizziness Upon Standing	C P N	Heart Bypass	C P N	Arrhythmia	C P N
High Cholesterol	C P N	Anemia	C P N	Hemochromatosis	C P N
Stroke and/or Heat Attack	C P N				
URINARY					
Pain on Urination	C P N	Increased Frequency	C P N	Frequency at Night	C P N
Frequent Infections	C P N	Inability to Hold	C P N	Kidney Stones	C P N
Frequent Urinary Tract Infections	C P N	Increased Urgency	C P N	Hesitancy	C P N
Kidney Disease	C P N				
BLOOD / PERIPHERAL VASCULAR					
Easy Bleeding or Bruising	C P N	Anemia	C P N	Deep Leg Pain	C P N
Varicose Veins	C P N	Thrombophlebitis	C P N		
OTHER					
Cancer? Yes / No What Kind: _____					

By signing below I agree I have answered the above questions truthfully and accurately to the best of my ability. I also understand that all cancellations within 24hrs of appointment time will incur a \$25 cancellation fee.

Signature: _____ **Date:** _____

Patient/Representative

If signed by representative, indicate relationship: _____

Witness: _____



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OFFICE POLICIES

Name: _____ Date: _____

Welcome to Absolute Health Medical Center. We look forward to addressing all of your health care needs. We encourage your questions and participation in all aspects of your health care.

Please read and initial each of the following:

_____ The office is open Monday through Friday from 9am-5pm for supplement purchases all other visits are by appointment only.

_____ **No Show/Cancellation Policy:** Any missed appointments or appointments that are cancelled with less than 24 hours notice will incur a No Show/Cancellation fee of \$40.00. After 2 no show appointments you will be responsible to pre-pay (non-refundable if missed) for your appointment as well as any incurred fees prior to being placed on the schedule. This policy applies to **ALL** scheduled appointments (i.e. Office visits, lab draws, HCG check-in, HBOT, massages, etc.)

_____ Prepaid treatments &/or services purchased through Tapmango, In-Office, or any other affiliated outlet will be forfeited for No-Show appointments in addition to the No Show /Cancellation fee of \$40.

_____ Payment for all services and medicinary items is due at the item of service unless other arrangements have been made.

_____ Unless a specific payment plan has been agreed upon and put into writing, our office reserves the right to charge interest on any outstanding balance on your account. After three (3) months, 5% compounded interest will begin to accrue.

_____ All prescriptions require a **MINIMUM** of **48 Business Hours** to process. If time allows we will get to them sooner, but this not a guarantee.

_____ I understand I have the option to have my insurance billed for any labs draw and understand that I am fully responsible for any charges incurred beyond what my insurance covers. Additionally, I understand I have been given the option to process my labs through the office at a reduced cash price and if I choose this option my insurance will not be billed for any lab work.

_____ For services provided in the clinic that are covered by insurance, the clinic will bill your insurance carrier on your behalf. If the physician is NOT in-network/contracted with your insurance carrier you will remain responsible for full payment of any and all fees not covered by your insurance carrier. You will be billed for those non-covered portions of your bill, for which payment in full is expected within 60 days of issuance of the bill. Your insurance policy is a contract between you and your carrier and Absolute Health Medical Clinic **CANNOT GUARANTY PAYMENT OF YOUR CLAIM(S).**

_____ I understand that some services as well as cancellation fees, rescheduling fees, telephone consultations and medicinary items are **NOT** covered by insurance and that payment is expected at time of service.

_____ I give the office staff (including practitioners) permission to contact me via telephone, text, and/or email to leave a message that may contain appointment or medical information if I am not available.

_____ By initialing this line I **give** Absolute Health Medical Center permission to use photos taken in the office on the Clinics social medical sites. If you choose not to have my photos used **DO NOT** initial this line.

By signing below I understand the information provided on this form and agree to the foregoing office and financial policies and will comply with them in all aspects.

Signature: _____ **Date:** _____

Patient/Representative

If signed by representative, indicate relationship: _____

Witness: _____

Updated 1-1-2021



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FINANCIAL POLICY

Name: _____ **Date:** _____

In an effort to keep our fees low, it is our policy that all patients pay at the time of service. For those patients without insurance our office offers a cash price discount for some services as well as a membership program. Please inquire at the front desk regarding those options.

If you have health insurance, we will generally bill your insurance on your behalf. If your health insurance requires a co-payment, we ask that you pay this fee at the time of service.

In order to bill your insurance your benefits will be verified along with any copay(s) and deductible amounts. While we try to ensure that the information is accurate, it is not a guarantee of payment from your insurance company. Any failure to pay on behalf of your insurance company is the Patients responsibility.

Most insurances will pay us directly for their portion of your bill (generally within 30-60 days), however, you remain responsible for ensuring that your bill is paid in full. If we are a participating provider with your insurance carrier, an "allowance" may be deducted from our regular fee. These types of allowances are NOT allowed if we are not contracted with your insurer. Any remaining portion after your insurance has made payment is the patient's responsibility, payment for any remaining balance is expected within 60 days of insurance payment.

If you have multiple insurances we will bill your secondary or tertiary insurance as a courtesy, but you are ultimately responsible for follow up billings.

Our professional fees have been developed using fee schedules published by the Centers for Medicare and Medicaid Services (CMS). CMS, a federal agency, has established a complex system that sets "relative value units" for each service we provide. These so-called "RV Units" are multiplied by a conversion factor to establish the price of our services. We have investigated contracted insurances and have chosen the lower multiplier for our rates. If you have any questions please feel free to contact our billing office for clarification.

If you are unable to pay your account within the 60-day time requirements we ask that you contact our billing office to make special arrangements. If you fail to pay your account in full your account WILL be turned over to a professional debt collection agency. In this event all fees assessed by the collection in the amount of 40% outstanding balance as permitted by ORS697.115 will be your responsibility, including interest and attorney fees.

By signing below I understand the information provided on this form and agree to the foregoing financial policy.

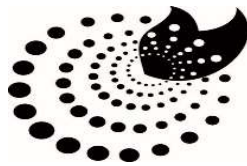
Signature: _____ **Date:** _____

Patient/Representative

If signed by representative, indicate relationship: _____

Witness: _____

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Absolute Health
MEDICAL CENTER

**INFORMED CONSENT FOR COVID-19 AND/OR
ANY OTHER COMMUNICABLE DISEASE RISK**

Patient Name _____ Date of Birth _____

Absolute Health Medical Center is following Oregon Health Authority guidelines and recommendation for the COVID-19 pandemic.

I understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact. I recognize that Dr. Justin Morse and the staff at Absolute Health Medical Center are closely monitoring the situation and have put in place reasonable and preventative measures to protect anyone who enters the premises. I hereby acknowledge and assume responsibility for the risk of becoming infected with COVID-19 and/or any other communicable diseases through this elective office visit/treatment/procedure. Absolute Health Medical Center will not be held liable for the contraction of COVID-19 or any other communicable disease.

Patient or Person Authorized to Sign for the Patient

Date

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Medical Records Release

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Gender: M / F Age: _____ Date of Birth: _____

I, _____, authorize the release of my medical records, specifically the following records, if such records exist, to be used on my behalf for the following purpose(s):

- () Medical records needed for continuity of care
- () Hormone replacement therapy procedure notes
- () Laboratory reports
- () Other (please specify) _____
- () Please send entire medical records to the above address

Records regarding services or treatments from other facilities that were provided to Absolute Health Medical Center on your behalf, MUST be obtained directly from that provider and/or facility.

In order to release future records I will provide the following code word to the staff at Absolute Health Medical Center. This code word will allow me to request records via email, fax and/or over the phone without having to sign additional releases.

Code Word: _____

This release will be valid for 365 days from the date signed.

By signing below I understand the information provided on this form and agree to the foregoing. I acknowledge that I have the right to terminate this consent at any time via written request. I also understand that my records will not be released to anyone without my written consent or code word validation. Medical records to be sent to other facilities will need to be requested directly from that provider. Additionally, I agree that if I am requesting my entire medical records be mailed, I will be responsible for the cost of shipping.

Signature: _____ Date: _____

Patient/Representative

If signed by representative, indicate relationship: _____

Witness: _____



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HIPPA CONSENT

Name: _____ Date: _____

I acknowledge that I have reviewed and understand Absolute Health Medical Center's HIPAA Policy that outlines that the clinic may:

- Disclose my information for treatment purposes and to coordinate my medical care;
- Disclose my information to ensure that I receive insurance benefits;
- Disclose my information internally to enhance the operation of its practice. This includes Absolute Health's commitment to reviewing the quality of care that is provided;
- Disclose my information to comply with a limited number of legal requirements, as outlined in the HIPAA policy, effective November 12, 2017.

I understand that I am entitled to a copy the HIPAA Policy and have received that copy (if requested).

I understand that the additional information regarding each of the above disclosures is provided in the full HIPAA Confidentiality Notice that has been provided to me, for review, on this date, and that only the minimum amount of information necessary will be disclosed for the purpose it was requested.

By signing below I understand the information provided on the HIPAA Policy and agree to the foregoing.

Signature: _____ Date: _____

Patient/Representative

If signed by representative, indicate relationship: _____

MEDICAL RELEASE OF INFORMATION

Please list family members and/or friends, if any, with whom we can share information with. Please identify the information we are authorized to discuss:

- | | | | |
|-----------|--|--------------|--|
| 1. No One | <input type="checkbox"/> | | |
| 2. Name | _____ | Relationship | _____ |
| | <input type="checkbox"/> Appointment Information | | <input type="checkbox"/> Medical and Treatment Information |
| 3. Name | _____ | Relationship | _____ |
| | <input type="checkbox"/> Appointment Information | | <input type="checkbox"/> Medical and Treatment Information |
| 4. Name | _____ | Relationship | _____ |
| | <input type="checkbox"/> Appointment Information | | <input type="checkbox"/> Medical and Treatment Information |

Signature: _____ Date: _____

Patient/Representative

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**HEALTH INSURANCE PORTABILITY AND ACCOUNTING ACT (HIPAA)
CONFIDENTIALITY NOTICE**

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.

General Information

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Confidentiality law. Under these laws Absolute Health Medical Center (herein referred to as "the clinic") may not say to a person (other than staff) that you are a patient at the clinic, or disclose any other protected information except as permitted by the federal laws referenced below.

The clinic must obtain your written consent before it can disclose information about you for payment purposes. For example, the clinic must obtain your written consent before it can disclose information to your health insurance company in order to be paid for services. Generally, must also sign a written consent before the clinic can share information for treatment purposes or for health care operations. However, federal law permits the clinic to disclose information in the following circumstances without your written permission:

1. To clinic staff for the purposes of providing treatment and maintaining clinic records;
2. Pursuant to an agreement with a business associate (i.e. clinical laboratories, pharmacies, record storage services, billing services etc.);
3. For research, audit or evaluations (i.e. State licensing review, accreditation, clinical data reporting as required by the State and/or Federal government;
4. To report a crime committed on the clinic's premises or against clinic personnel;
5. To medical personnel in a medical emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illness as required by State law;
8. As allowed by a court order

Before the clinic can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Your Rights

- Under HIPAA you have the right to request restrictions on certain uses and disclosures or your health and treatment information. The clinic is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical

- You have the right to request that we communicate with you by alternative means or at an alternative location (i.e. another address). The clinic will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the clinic, except to the extent that the information contains information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the clinic's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.
- If your request to any of the above is denied, you have the right to request a review of the
- To make any above requests, you must fill out the appropriate form that will be provided by the clinic.
- You also have the right to receive a paper copy of this notice.

The Use of Your Information at Absolute Health Medical Center

In order to provide you with the best care, the clinic will use your health and treatment information in the following ways:

- Communication among program staff (including students or other interns) for the purpose of treatment needs, treatment planning, progress reporting and review, staff supervisors, incident reporting, medication administration, billing operations, medical record maintenance, and other treatment related processes.
- Communication with Business Associates such as clinical laboratories (blood work, urinalysis), other medical professionals for continued care, and long term record storage.

Absolute Health Medical Centers Duties

The clinic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The clinic is required by law to abide by the terms of this notice. The clinic reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The clinic will provide current patients with an updated notice, and will provide affected former patients with the new notices with substantive changes are made in the notice.

Complaints and Reporting Violations

Patients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. The patient may complete a Privacy Complaint Form (available at <https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html>) and submit the form to the:

Centralized Case Management Operations
US Department of Health & Human Services
200 Independence Ave, S.W.
Room 509 HHH Bldg.
Washington, D.C. 20201

You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality law by a clinic is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.