

Patient Registration

Patient _____ Last Name _____ First Name _____ Middle Initial _____

Sex M F Age _____ Date of Birth MM / DD / YYYY Social Security No. _____

The following questions are required by federal regulations

Which category or categories best describe your race?

- White Native Hawaiian or Other Pacific Islander
 Black or African American American Indian or Alaska Native
 Asian Unable or unwilling to provide this information

Do you consider yourself Hispanic or Latino?

- Yes
 No
 Unable or unwilling to provide this information

What is your preferred language including those for the hearing impaired? _____

Marital Status S M W D Sep. Spouse (or parent if a minor) _____ Last Name _____ First Name _____

Home Address _____ Street _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Email _____

Employer _____ How Long _____ Occupation _____

Employer's Address _____ Street _____ City _____ State _____ Zip Code _____

Emergency Contact _____ Last Name _____ First Name _____ Relationship _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone _____

Referring Physician / Source _____ Phone _____

Primary Insurance Company _____

Identification No. _____ Group No. _____ Effective Date MM / DD / YYYY

Policy Holder _____ Last Name _____ First Name _____ Social Security No. _____ Date of Birth MM / DD / YYYY

Relationship to Patient _____ Employer _____

Secondary Insurance Company _____

Identification No. _____ Group No. _____ Effective Date MM / DD / YYYY

Policy Holder _____ Last Name _____ First Name _____ Social Security No. _____ Date of Birth MM / DD / YYYY

Relationship to Patient _____ Employer _____

Please complete the next page

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. **I understand that I am responsible for all charges not covered by my insurance.** If this account should be referred to a collection agency, I will be responsible for all collection and legal fees. I authorize the release of any medical or other information necessary to process my medical claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment. I have read and understand the office policy and procedures.

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. **I understand that I am responsible for all charges not covered by my insurance.** If this account should be referred to a collection agency, I will be responsible for all collection and legal fees. I authorize the release of any medical or other information necessary to process my medical claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment. I have read and understand the office policy and procedures.

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

PROBLEM CHECKLIST

If you have recently or recurrently noted the any of the following problems, please check (✓) the box next to the condition listed.

General	<input type="checkbox"/> Fever <input type="checkbox"/> Sweats <input type="checkbox"/> Unintended weight change (how much over what period? _____)	<input type="checkbox"/> Chills <input type="checkbox"/> Malaise or “feeling ill” <input type="checkbox"/> Fatigue
Head	<input type="checkbox"/> Headache	<input type="checkbox"/> Head injury
Ears	<input type="checkbox"/> Ringing <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge	<input type="checkbox"/> Change in hearing <input type="checkbox"/> Blockage <input type="checkbox"/> Dizziness
Nose	<input type="checkbox"/> Congestion <input type="checkbox"/> Persistently discolored discharge <input type="checkbox"/> Sinus pressure	<input type="checkbox"/> Clear discharge <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Sinus pain
Throat	<input type="checkbox"/> Sore throat <input type="checkbox"/> Laryngitis <input type="checkbox"/> Itchy throat	<input type="checkbox"/> Dental problem <input type="checkbox"/> Persistent hoarseness <input type="checkbox"/> Snoring
Eyes	<input type="checkbox"/> Change in vision <input type="checkbox"/> Flashing or scintillating lights <input type="checkbox"/> Partial loss of vision (central, peripheral, or field) <input type="checkbox"/> Eye pain	<input type="checkbox"/> Sudden loss of vision <input type="checkbox"/> Dark spots or “floaters” <input type="checkbox"/> Eye discharge <input type="checkbox"/> Itchy or irritable
Heart	<input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Swelling of feet or ankles	<input type="checkbox"/> Palpitations <input type="checkbox"/> Racing heart
Lungs	<input type="checkbox"/> Trouble breathing (intermittent or constant) <input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing <input type="checkbox"/> Painful breathing
Digestive	<input type="checkbox"/> Heartburn or acid reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Excessive bloating or gas	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Black tarry stool
Bones and Joints	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain (stiffness or restricted mobility)	<input type="checkbox"/> Neck pain <input type="checkbox"/> Muscle aches
Neurological	<input type="checkbox"/> Weakness <input type="checkbox"/> Abnormal sensations <input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness <input type="checkbox"/> Fainting <input type="checkbox"/> Restless legs
Psychological	<input type="checkbox"/> Anxious <input type="checkbox"/> Feeling hopeless, helpless, or worthless <input type="checkbox"/> Unable to enjoy life <input type="checkbox"/> Uncontrollable anger or irritability <input type="checkbox"/> Wanting to hide, disappear, or die	<input type="checkbox"/> Panic attack <input type="checkbox"/> Persistent sadness <input type="checkbox"/> Insomnia <input type="checkbox"/> Poor appetite or stress eating <input type="checkbox"/> Wanting to hurt someone
Skin	<input type="checkbox"/> Abnormal or changing mole <input type="checkbox"/> Lesions of concern <input type="checkbox"/> Swollen glands <input type="checkbox"/> Change in texture	<input type="checkbox"/> Rashes <input type="checkbox"/> Dryness <input type="checkbox"/> Bruising <input type="checkbox"/> Hair or nail changes

IMMUNIZATIONS

Please list month and year of your most recent immunizations.

Hepatitis A	MM / YYYY	Measles	MM / YYYY	Tetanus ¹	MM / YYYY	Chicken Pox	MM / YYYY
Hepatitis B	MM / YYYY	Flu ²	MM / YYYY	Pneumonia ³	MM / YYYY	Meningococcal	MM / YYYY
_____	MM / YYYY	_____	MM / YYYY	_____	MM / YYYY	_____	MM / YYYY

¹ Recommended every 10 years ² Recommended every year ³ Recommended every 5 years

ALLERGIES

Are you allergic or intolerant to any medications? Y N
If "yes," please list and describe your reaction(s).

MEDICATIONS

Please list all medications you are using including vitamins, herbal supplements, and contraception.

SURGERIES

Please list any surgeries or procedures (include colonoscopies) you have had with approximate dates.

PREVENTIVE HEALTH

Please provide the following information:

Caffeine? <input type="checkbox"/> Y <input type="checkbox"/> N Type: _____ Caffeinated beverages per day? _____	Alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N Type? _____ Drinks per week? _____ Quit date? <u>MM</u> / <u>YYYY</u>
Tobacco? <input type="checkbox"/> Y <input type="checkbox"/> N Type: _____ Packs per day? _____ Quit date? <u>MM</u> / <u>YYYY</u>	Other substances? <input type="checkbox"/> Y <input type="checkbox"/> N Drug(s)? _____ Frequency? _____
Seat belts? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never	Helmet use? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never
Drive at speed limit? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never	Protective sports gear? <input type="checkbox"/> Always <input type="checkbox"/> Occ. <input type="checkbox"/> Never
Number of days >30 minutes exercise per week? _____	Foreign travel planned? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you have reason to fear for your safety? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you ever been physically or mentally harmed by another? <input type="checkbox"/> Y <input type="checkbox"/> N
Other "high risk" activities (e.g., skydiving, motorcycles, scuba diving)? <input type="checkbox"/> Y <input type="checkbox"/> N Type? _____	

FOR WOMEN

Please provide the following information:

Number of pregnancies? _____ How many resulted in live birth(s)? _____ Miscarriage(s)? _____ Abortion(s)? _____	
Date of last period? <u>MM</u> / <u>YYYY</u>	Could you be pregnant now? <input type="checkbox"/> Y <input type="checkbox"/> N
Last Pap Smear or female exam? <u>MM</u> / <u>YYYY</u>	Last mammogram? <u>MM</u> / <u>YYYY</u>
Method of birth control? _____	Age at first period or menopause? _____
Prior abnormal Pap Smear? <input type="checkbox"/> Y <input type="checkbox"/> N If so, year: <u>YYYY</u>	Sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N
History of human papilloma virus? <input type="checkbox"/> Y <input type="checkbox"/> N	Planning pregnancy in next year? <input type="checkbox"/> Y <input type="checkbox"/> N

FOR MEN

Please provide the following information:

Last PSA (blood prostate level)? <u>MM</u> / <u>YYYY</u>		Sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N
Urine flow problems? <input type="checkbox"/> Y <input type="checkbox"/> N	Prostate problems? <input type="checkbox"/> Y <input type="checkbox"/> N	Lump or pain in testicle? <input type="checkbox"/> Y <input type="checkbox"/> N
Erection issues? <input type="checkbox"/> Y <input type="checkbox"/> N	Loss of height? <input type="checkbox"/> Y <input type="checkbox"/> N	Lack of energy? <input type="checkbox"/> Y <input type="checkbox"/> N

FOR CHILDREN

Please provide the following information:

Normal development? <input type="checkbox"/> Y <input type="checkbox"/> N	School performance issues? <input type="checkbox"/> Y <input type="checkbox"/> N
Normal growth? <input type="checkbox"/> Y <input type="checkbox"/> N	Social or friends concerns? <input type="checkbox"/> Y <input type="checkbox"/> N
Normal language? <input type="checkbox"/> Y <input type="checkbox"/> N	Behavioral concerns <input type="checkbox"/> Y <input type="checkbox"/> N

Is there anything of an unusually sensitive nature you would like to discuss with your physician?

Y N

ADDITIONAL INFORMATION

Please use this space to complete any of the above questions or provide other relevant information.

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient



Consent to Annual Administrative Fee

LifeScape Medical Associates, PC is committed to the highest level of medical care and innovative, patient-centered services. In order to meet this standard and cover the cost of a growing multitude of non-covered and excluded administrative expenses, LifeScape charges an annual fee of \$25 per patient age five through twenty-three and \$60 per patient age twenty-four and above. This fee is due at the time care is established and annually thereafter until LifeScape is notified in writing that care has been discontinued. Failure to provide payment when due may result in termination of care. Patients unable to pay due to financial hardship may contact LifeScape staff to discuss other options. LifeScape reserves the right to change the annual fee in its sole discretion.

LifeScape's administrative fee allows it to provide services not covered by insurance without levying multiple charges. Depending on your health plan, non-covered or excluded services may include, but are not necessarily limited to:

- Completion of many standard documents including Family Medical Leave Act and Return to Work forms, immunization records and school, camp and sport medical forms, pharmacy forms including change requests and special authorizations
- Medical record duplication and mailing other than as required by law
- Appointment reminders
- Internet-based appointment and prescription refill requests, health maintenance and immunization schedules, practice forms, and account statements

For your convenience, LifeScape also offers these services at no additional charge:

- Near same-day appointments with the first available provider
- Extended hours and lunch hour care
- Direct, after-hours telephone access to a LifeScape physician

We hope that you will find our annual fee convenient and preferable to the periodic charges that otherwise would be necessary. Your feedback is extremely important to us. Please contact us if you need further information or have suggestions for improvement.

Receipt acknowledged and annual fee agreed to by:

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

Annual Administrative Fee *Easy Pay* Enrollment

LifeScape Medical Associates is committed to environmental stewardship and sustainability. To reduce paper consumption, LifeScape utilizes *Easy Pay* paperless billing—the same system used by utilities, hotels, and countless other merchants. With *Easy Pay*, your credit card information is maintained securely within our medical record. Annual administrative fees are processed automatically when due, saving you time and money and preventing substantial amounts of greenhouse gases and waste emissions from entering the environment each year.

Yes, I would like to save time and money and protect the environment by enrolling in *Easy Pay*.


By providing the payment information below, I authorize LifeScape Medical Associates, PC to maintain and utilize that information to process its annual fee for non-covered administrative services when due for the following individuals:

Patient 1:	First Name	Middle Initial	Last Name	Self or Relationship
Patient 2:	First Name	Middle Initial	Last Name	Relationship
Patient 3:	First Name	Middle Initial	Last Name	Relationship
Patient 4:	First Name	Middle Initial	Last Name	Relationship
Patient 5:	First Name	Middle Initial	Last Name	Relationship

I understand that, upon my request, LifeScape will send me a copy of my statement and receipt evidencing charges to my account. I further understand that this authorization is valid until cancelled through written notice to LifeScape.

Cardholder Name:

Cardholder Address:

Check One:   

Non-Health Savings Account (HSA) cards only

Account Number:

Security Code: Expiration Date: /

Cardholder Signature: Date:

Consent to Financial Policy

THIS CONSENT CONTAINS IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT FOR PROFESSIONAL SERVICES RENDERED BY LIFESCAPE MEDICAL ASSOCIATES, PC. IT OUTLINES LIFESCAPE'S RESPONSIBILITIES AND THOSE OF ITS PATIENTS WITH REGARD TO BILLING AND PAYMENT FOR GOODS AND SERVICES RENDERED.

1. LifeScape Medical Associates, PC ("LifeScape") and most of its physicians participate with many health insurance plans. The most current list of insurance selections can be found on LifeScape's web site and confirmed by calling our office. If the patient is a member of one of these plans and receives professional services from one of our in-network providers, LifeScape will submit a claim to the plan for professional services rendered and, except as noted below, the patient will not be charged. It is the patient's responsibility to make payment at the time of service for any co-payment, co-insurance, or deductible due. **Any services not covered by a patient's insurance plan are also the patient's responsibility and payment in full is required at the time of service or denial by the insurer. Insurer delays and split claims are common and beyond LifeScape's control. Consequentially, patients may be billed, in whole or in part, well after the date of service. Insurance claims unpaid or only partially paid by the patient's plan 60 days following their submission by LifeScape may be billed to the patient directly with payment due upon receipt. LifeScape is not a party to the patient's insurance contract and ultimate financial responsibility for services rendered lies with the patient or the patient's guarantor.**
2. If a patient is not a member of an insurance plan with which LifeScape participates, including Medicare, or receives professional services from one of our out-of-network providers, **the patient must make payment in full at the time of service.** As a courtesy, LifeScape will submit an insurance claim on the patient's behalf and the patient can anticipate reimbursement according to the insurer's policies.
3. LifeScape provides or orders those professional services, products, tests, and referrals it believes to be in its patients' best medical interests. LifeScape, however, neither guarantees nor represents that its patients' insurance plans will deem such services, products, tests, and referrals "covered" or the charges "reasonable and customary." LifeScape is not responsible for its patients' insurance plans' arbitrary denials or limits to payment.
4. It is the patient's responsibility to ensure that any authorization or referral for treatment required by his or her insurance plan is received **before their LifeScape appointment.** In the absence of a required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for the services rendered by LifeScape.
5. It is the patient's responsibility to provide LifeScape with current insurance information and to present an active insurance card at each visit.
6. An adult accompanying a child under age 18 and/or the parent or guardian of the child is responsible for payment according to the terms described herein. LifeScape may reschedule non-emergency treatment for unaccompanied children unless charges have been pre-authorized or payment at time of service has been arranged.
7. LifeScape's staff is happy to help with insurance questions relating to a filed claim or to provide reasonable additional information required by the insurance carrier to process a claim. However, patients should direct questions about coverage

for specific treatments or procedures to a representative of their insurance company's member services department. The phone number for member services is usually on the insurance card.

8. Payment for professional services may be made by cash, check, debit card, or credit card. LifeScape accepts VISA®, MasterCard®, and American Express®. As a convenience, LifeScape offers *Easy Pay* credit card transactions for annual administrative fees—providing a safe, secure way to pay future charges without additional billings or paperwork. *Easy Pay* enrollment forms are available at our office and on our web site.
9. LifeScape charges an annual fee of \$25 per patient age five through twenty-three and \$60 per patient age twenty-four and above. This fee helps defray the cost of non-covered administrative expenses and is due at the time care is established and annually thereafter until LifeScape is notified in writing that care has been discontinued. All patients receive and are required to execute a separate Consent to Annual Fee prior to receipt of services. The foregoing notwithstanding, concierge patients are exempt from annual fees for non-covered administrative expenses and are not required to execute a Consent to Annual Fee.
10. Failure to timely cancel an appointment denies LifeScape the opportunity to fill that time slot and may prevent other patients from receiving the care they require. Therefore, LifeScape charges a fee of \$75 for appointments cancelled with less than six office hours advance notice. A patient who fails to keep three or more appointments without prior notice of cancellation may be discharged from LifeScape.
11. A \$25 returned item fee will be charged for each check returned or charge denied regardless of cause.

12. Interest will be charged at an annual rate of 18% on all past due patient balances.
13. Delinquent account balances may be referred to an agency for collection. All collection costs including, without limitation, attorney fees and court costs are and will remain the sole responsibility of the patient or the patient's guarantor.
14. In the event of a documented personal financial hardship, LifeScape may be able to offer special financial arrangements including payment plans and waiver of select fees.
15. Patients with a past due balance may be required to pay their balance in full before additional professional services are rendered.
16. Prompt payment for services rendered is an essential element of the patient-physician relationship. Failure to promptly pay for professional services rendered or respond to communications from our office regarding payment may result in discharge from the practice.
17. LifeScape reserves the right to change this financial policy in its sole discretion.

For More Information:

We are eager to help you in any way we can. We firmly believe that communication is the key to a successful patient-physician relationship.

If you have questions or would like additional information, you may contact our Billing Department at (480) 860-5500 extension 105.

LifeScape Medical Associates, PC

8757 East Bell Road
Scottsdale, Arizona 85260
www.lifescapemed.com

Effective Date: June 1, 2009

Receipt acknowledged and financial policy agreed to by:

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

LifeScape Medical Associates, PC (“LifeScape”) is required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. LifeScape must abide by the terms set forth in this notice. However, LifeScape reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information LifeScape maintains. LifeScape will post any revised notice in a prominent location in our office and, upon request, will provide to you a copy of the revised notice.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Treatment. LifeScape may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. LifeScape may also disclose your protected health information to other health care providers who may be treating you or involved in your health care. For example, LifeScape may disclose your protected health information to a specialist involved in your treatment.

Payment. LifeScape may use and disclose your protected health information to obtain payment for the health care services LifeScape provides you or to determine whether LifeScape may obtain payment for services LifeScape recommends for you. LifeScape may also disclose your protected health information to another health care provider, health care clearinghouse, or health plan for their payment activities. For example, LifeScape may include with a bill to a third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. LifeScape may use and disclose your protected health information to support our business activities. For example, LifeScape may use your protected health information to review and evaluate our treatment and services or to evaluate our staff’s performance while caring for you. LifeScape may disclose your protected health information for certain health care operations of another health care provider, health care clearinghouse, health plan for certain health care operations, and to an “organized health care arrangement” LifeScape participates in for its health care operations. LifeScape may

also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, LifeScape may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

Appointment Reminders and Treatment

Alternatives. LifeScape may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment, or to tell you about or to recommend possible alternative treatments or other health-related benefits or services that may be of interest to you.

Persons Involved in Your Care. LifeScape may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person’s involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, LifeScape may disclose the information as necessary if LifeScape determines that it is in your best interest based on our professional judgment.

Notification. LifeScape may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location, general condition, or death.

Disaster Relief. LifeScape may use and disclose your protected health information 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 health care.

Research. LifeScape may use and disclose your protected health information to researchers whose research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. LifeScape may also disclose to certain third parties a limited data set containing your protected health information for research purposes.

As Required by Law. LifeScape may use and disclose your protected health information to the extent the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.

Public Health. LifeScape may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury, or disability. If directed by the public health authority, LifeScape may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.

Abuse or Neglect. LifeScape may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If LifeScape believes you are a victim of abuse, neglect, or domestic violence, LifeScape also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.

Communicable Diseases. If authorized by law, LifeScape may disclose your protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

Legal Proceedings. LifeScape may disclose your protected health information in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; to the extent the disclosure is expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request, or other lawful process.

Law Enforcement. If certain legal requirements are met, LifeScape may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes, identification and location of suspects, fugitives, material witnesses, or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.

Coroners, Funeral Directors, and Organ

Donation: LifeScape may disclose your protected health

information to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. LifeScape may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out her duties or in reasonable anticipation of death. Finally, LifeScape may use or disclose your protected health information for facilitating organ, eye, or tissue donation and transplantation.

To Avert a Serious Threat to Public Health or Safety. Consistent with applicable laws, if LifeScape believes using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, LifeScape may use and disclose your protected health information. LifeScape may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, LifeScape may use or disclose your protected health information for activities deemed necessary by appropriate military command authorities, for determining your eligibility for benefits by the Department of Veterans Affairs, or to foreign military authority if you are a member of that foreign military service. LifeScape may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation. LifeScape may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Department of Health and Human Services. As required by law, LifeScape may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws.

Written Authorization. Except as stated in this notice, LifeScape will not use or disclose your protected health information without your written authorization. You may revoke this authorization at any time, in writing, except to the extent that LifeScape has used or disclosed your information in reliance on the authorization.

Food and Drug Administration. LifeScape may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or track products; to enable product recalls; to make repairs or replacements; or to conduct post-marketing surveillance.

Inmates. LifeScape may use and disclose your protected health information if you are an inmate of a correctional facility and LifeScape created or received your protected health information in the course of providing care to you.

YOUR HEALTH INFORMATION RIGHTS

Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that LifeScape maintains about you in our designated record set for as long as LifeScape maintains that information. This designated record set includes your medical and billing records, as well as any other records LifeScape uses for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial.

If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our Privacy Officer, c/o LifeScape Medical Associates, PC, 8757 East Bell Road, Scottsdale, AZ 85260. LifeScape may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. LifeScape has 30 days to respond to your request for information that LifeScape maintain at our practice sites. If the information is stored off-site, LifeScape has up to 60 days to respond, but must inform you of this delay.

Request Amendment. You have the right to request that LifeScape amend your protected health information. You must make this request in writing to our Privacy Officer. The request must state the reason for the amendment.

LifeScape may deny your request if it is not in writing or does not state the reason for the amendment. LifeScape may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which you are permitted to inspect and copy; the information is not part of our designated record; or is accurate and complete, in our opinion.

Request Restrictions. You have the right to request a restriction or limitation of how LifeScape uses or disclose your protected health information for treatment, payment, or health care operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although LifeScape is not required to agree to your requested restriction, if LifeScape does agree, LifeScape will comply with your request unless the information is needed for emergency treatment. Please contact our Privacy Officer as set forth in this notice to request a restriction.

Accounting of Disclosures. You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment,

or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of the request. Your request must be in writing and must state the time period for the requested information.

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, LifeScape may charge you a fee for the costs of providing the subsequent list. LifeScape will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how LifeScape communicates with you to preserve your privacy. LifeScape may condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our Privacy Officer. The request must specify how or where LifeScape is to contact you. LifeScape will accommodate all reasonable requests.

File a Complaint. You have the right to file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services if you believe LifeScape has violated your privacy rights. Complaints to our Privacy Officer must be in writing. LifeScape will not retaliate against you for filing a complaint.

For More Information:

If you have questions or would like additional information, you may contact our Privacy Officer at 480-860-5500.

LifeScape Medical Associates, PC

8757 East Bell Road
Scottsdale, Arizona 85260
www.lifescapemed.com

Effective Date: October 1, 2003

Acknowledgement of Receipt of Notice Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Lifescope Medical Associates, PC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

Signature of the Patient or the Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

FOR OFFICIAL USE ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of the Notice of Privacy Practices of LifeScape Medical Associates, PC However, I could not obtain written acknowledgement because:

- Individual refused to sign this Acknowledgement
- Communications barrier prohibited obtaining written acknowledgement
- An emergency situation prevented obtaining written acknowledgement
- Other (please specify) _____



8757 East Bell Road
 Scottsdale, Arizona 85260
 Tel. 480.860.5500
 Fax. 480.860.5511
 www.lifescapemed.com

Authorization to Disclose Protected Health Information to LifeScape Medical Associates, PC

Patient whose Protected Health Information is sought:

Patient _____ Last Name _____ First Name _____ Middle Initial _____ Date of Birth MM / DD / YYYY

Home Address _____ Street _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Person or entity from which Protected Health Information should be disclosed (“Provider”):

Name _____ Name of Person or Entity _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone Number _____

Entity to which Protected Health Information should be disclosed:

LifeScape Medical Associates, PC
 8757 East Bell Road
 Scottsdale Arizona 85260

Attn: _____

Description of Protected Health Information to be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Lab Tests |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Other _____ Specify _____ |

Purpose(s) of the disclosure:

- | | |
|--|--|
| <input type="checkbox"/> Supplemental Care | <input type="checkbox"/> Insurance Coverage or Payment of Care |
| <input type="checkbox"/> Second Opinion | <input type="checkbox"/> Workers’ Compensation |
| <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Other _____ Specify _____ |

I hereby authorize Provider to release Protected Health Information (“Information”) to LifeScape Medical Associates, PC. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eighty (180) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

 Signature of the Patient or the Patient’s Legal Representative

 Date

 Print Name

 If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient