Rowan CARDIOLOGY

Patient Advanced Care Planning Form

Patient Information:

- Name: _____ - Date of Birth: _____

Surrogate Decision Maker:

- Name: _____ - Relationship to Patient: _____
- Phone Number: _____

Advance Directives:

- [ ] Yes, I have one.
- [ ] No, I do not have one.

Patient Signature: _____

Date: _____

Rowan CARDIOLOGY

Revised 04/24/24

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES				
FIRST NAME:	MI:	LAST NAME:		
ADDRESS:		CITY:	STATE:	ZIP CODE:
❑ FEMALE ❑ MALE ❑ OTHER	SSN (last 4 digits):		DOB:	
PRIMARY PHONE: ❑ HOME ❑ CELL		SECONDARY PHONE: ❑ CELL ❑ WORK ❑ FAMILY/FRIEND		
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DOMESTIC PARTNER ❑ DIVORCED ❑ WIDOW				
EMAIL:		REMINDER PREFERENCE: ❑ EMAIL ❑ PHONE ❑ TEXT		
PRIMARY CARE PROVIDER: (LAST, FIRST)		REFERRING PHYSICIAN: (LAST, FIRST)		
PHARMACY:	LOCATION:	PHONE NUMBER:		
RACE: ❑ AMERICAN INDIAN OR ALASKA NATIVE ❑ HISPANIC ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN ❑ NATIVE HAWAIIAN OR PACIFIC ISLANDER ❑ WHITE				
OTHER TREATING PHYSICIANS YOU WOULD LIKE INFORMATION SHARED WITH: (WITH FIRST AND LAST NAME)				
1)		2)		

INSURED/RESPONSIBLE PARTY				
PRIMARY INSURANCE / complete form or provide card (or copy of) insurance card:				
SUBSCRIBER FIRST NAME:	MI:	LAST NAME:		
SUBSCRIBER RELATIONSHIP: ❑ SELF ❑ CHILD ❑ SPOUSE ❑ PARENT ❑ GUARDIAN ❑ PARTNER				
MEMBER ID NUMBER:	GROUP NUMBER:	EFFECTIVE DATE:		
PLAN TYPE:				
SECONDARY INSURANCE NAME / complete form or provide card (or copy of) insurance card:				
SUBSCRIBER FIRST NAME:	MI:	LAST NAME:		
SUBSCRIBER RELATIONSHIP: ❑ SELF ❑ CHILD ❑ SPOUSE ❑ PARENT ❑ GUARDIAN ❑ PARTNER				
MEMBER ID NUMBER:	GROUP NUMBER:	EFFECTIVE DATE:		
PLAN TYPE:				

ASSIGNMENT AND RELEASE INSURANCE

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. I understand that the physician has a right to change their privacy practices and that I may obtain any revised notices at the clinic. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

PATIENT FINANCIAL POLICY

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies explained in the Rowan Cardiology Patient Financial Policy Form. There is a detailed form available upon request.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	DATE:

Rowan CARDIOLOGY

FINANCIAL POLICY

Thank you for choosing Rowan Cardiology to participate in your medical care. To provide you with a full understanding of your financial obligations, an important aspect of your medical care, we have developed the following policies:

ALL PATIENTS ARE FINANCIALLY RESPONSIBLE FOR SERVICES PROVIDED.

- Rowan Cardiology requires that you provide a copy of your current insurance card and photo ID at every visit.
- Rowan Cardiology will bill your primary and secondary insurance on your behalf. You will be responsible for services rendered that are not covered by your Insurance or the amount that the Insurance deems is patient responsibility.
- A requirement of both Rowan Cardiology and your insurance company; co-payments are due at the time of service.
- Payment of co-insurance or any charges not covered by your plan is required at the time of services.
- Medicare recipients must update the National File with any changes by calling 1-800- MEDICARE.
- Payment is required in full at the time of service from uninsured patients unless arrangements have been made in advance.
- Unless previous arrangements made, account balance over 90 days will be sent to a collection agency.
- A fee of $25 will be charged to you for returned checks, plus any bank fees incurred.

APPOINTMENTS

- A $50 fee will be assessed for canceled appointments without 24 hours' notice.
- Patients who accumulate a total of three "No Shows" in a calendar year may be terminated from the practice.

OUTSIDE DOCUMENT COMPLETION

- FMLA/Disability/Insurance forms requiring the Physician's office to fill out will be charged as follows

1 Document	$25.00	***This fee must be paid at the time of dropping off the document(s).***
2 Document	$40.00	
3 or more Documents	$50.00	

REFERRALS/AUTHORIZATIONS

- It is the patient's responsibility to ensure that any referrals or authorization for treatment are provided to the office prior to your appointment. If the authorization or referral is not obtained prior to your visit, you will be expected to pay for all charges at the time of your visit.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about our Financial Policy should be directed to the front desk personnel.

I have read and understand the Financial Policy, I accept responsibility for services provided by Rowan Cardiology

Signature of Financially Responsible Party_____ Date _____

Printed Name _____

Rowan CARDIOLOGY

HIPAA

HIPAA PATIENT ACKNOWLEDGMENT FORM

Our electronic Notice of Privacy Practices (NPP) provides information about how Rowan Cardiology may use and disclose protected Health information (PHI) about you. The practice provides this form to further comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patients' Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgment form. If you would like a written copy of our NPP, please request this from the front desk.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. Please review the following for further delineation of your wishes.

I, _____, hereby authorize the release of my protected health information (PHI) to the family members listed below, and consent to leaving messages regarding appointment times and test results at my designated phone number, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Family Members Authorized to Receive PHI:
Name:_____

Relationship to patient:_____

DOB:_____

Specified Phone Number for Messages:
_____

By signing this authorization, I acknowledge that I have read and understood the HIPAA Privacy Rule and authorize the release of my PHI to the specified individuals for the purposes outlined above.

I assume responsibility to inform the practice of any changes in the above information.

Print Patient's Name / Responsible Party_____Patient DOB_____

Signature _____Today's Date_____

Rowan CARDIOLOGY

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Allergies

☐ *None/No Known Allergies* ☐ *Adhesive Tape* ☐ *Anesthesia* ☐ *Asprin* ☐ *Codeine* ☐ *Latex*
☐ *Iodine/Shellfish/Contrast Dye* ☐ *Morphine* ☐ *Penicillin* ☐ *Sulfa Drugs* ☐ *Midazolam/Versed*
☐ *Other*_____

Reaction(s): _____

Personal Medical History: HAVE YOU ***EVER*** HAD ANY OF THE FOLLOWING?

PROBLEM	✓
I Have No Medical Problems	
Asthma	
Environmental Allergies	
Cerebrovascular Accident (Stroke)	
Intermittent Stroke-Like Symptoms / TIAs	
Dizziness (Syncope)	
Migraine Headaches	
Seizure Disorders	
Cancer: Type _____ Year_____	
Atrial Fibrilation / Intermittent Rapid Heart Beat	
Crohn's Disease	
Peripheral Antherosclerosis (PAD) Artery Blockages in the Legs or Arms	
Heart Burn / Acid Reflux / GERD	
Hepatitis	
Liver Disease	
Bleeding Disorder: Type_____	
Diabetes Type 1	
Diabetes Type 2	
Hyperlipidemia (High Cholesterol)	
Hyperthyroidism	
Kidney Disease	
Dialysis Dependent	
Obesity	
Thyroid Disease	
Cataracts	
Glaucoma	

PROBLEM	✓
Blood Clots or DVT in Legs	
Blood Clot in Lung (P.E.)	
Cardiac Arrhythmia	
Cardiomyopathy	
Congestive Heart Failure (CHF)	
Coronary Artery Disease (CAD) / Heart Disease	
Heart Attack	
High Blood Pressure /Hypertension	
Non-Healing Leg Ulcers / Sores	
Varicose Veins	
Arteriosclerotic Heart Disease (ASHD)	
HIV / AIDS	
Angina/Intermittent Chest Pain	
Aneurysm, Other Type: _____	
Abdominal Aortic Aneurysm	
Chronic Generalized Pain	
Gout	
Lupus	
Raynaud's Phenomenon	
Alcoholism	
Using Other Non-Prescribed Drugs	
Dementia / Alzheimer's	
Swallowing Problems	
Sleep Apnea	
Chronic Obstructive Pulmonary Disease (COPD) Emphysema	
Hard of Hearing / Hearing Loss	

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PATIENT MEDICAL HISTORY

PATIENT NAME:_____

SURGICAL HISTORY

SURGERY	✓	APPROX. DATE OR YEAR
Abdominal Aortic Aneurysm Repair / Endograft		
Amputation (Body Part)		
Arterial Bypass Surgery Legs		
Arterial Stents – Legs		
Atherectomy – Legs		
AV Fistula		
Back Surgery		
Carotid Endarterectomy		
Cholecystectomy / Gallbladder		
Heart Bypass Surgery		
Heart Stenting Procedures		

SURGERY	APPROX. DATE OR YEAR
List All Other Surgeries:	

FAMILY HISTORY: Please indicate if any of your immediate relatives have any of the following by a ✓ **in the appropriate box.**

MEDICAL HISTORY	FATHER	MOTHER	BROTHER	SISTERS
Alive				
Deceased				
Aneurysm				
Atherosclerosis of the Legs / Poor Circulation				
Carotid Artery Disease				
Heart Disease (ASHD) / Heart Attack				
Bleeding Disorder (*What Type?*)				
Blood Clots or DVT in Legs				
Cancer (*What Type?*)				
Chronic Obstructive Pulmonary Disease (COPD) (Emphysema)				
Cerebrovascular Accident (Stroke)				
Diabetes				
Kidney Disease				
High Blood Pressure / Hypertension				
Hyperlipidemia (High Cholesterol)				
Thyroid Disease				
Varicose Veins				
Unknown History				

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SOCIAL / MEDICAL HISTORY

PATIENT NAME:_____

SOCIAL HISTORY

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

SMOKING HABITS

☐ Never Smoked ☐ Current Smoker ☐ Former Smoker ☐ E/Vape

Drinking Habits

☐ Heavy ☐ Social ☐ Moderate ☐ Non-Drinker

MEDICATIONS: List any medications you are currently taking – please include over the counter (Please Print)

MEDICATION	DOSAGE/FREQUENCY	PRESCRIBING DR.
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

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REVIEW OF SYSTEMS

PATIENT NAME:_____

REVIEW OF SYSTEMS: **Please mark only those that apply within the *LAST 30 DAYS***

PROBLEM	✓
GENERAL	
Dizziness	
Fever / Chills	
Fatigue	
Use of a Walking Device	
HEAD/EYE/EARS/NOSE/THROAT	
Blurred Vision Right / Left	
Temporary Loss of Vision Right / Left	
Severe Headaches	
Hearing Loss Right / Left	
Bloody Nose	
Difficulty Swallowing	
Drooping on One Side of Face Right / Left	
CARDIOVASCULAR	
Chest Pain / Pressure	
Palpitations / Skipped Beats	
Shortness of breath All the time Or with activity	
Pacemaker	
Coronary artery bypass or cardiac stents	
Swelling in Lower Extremities	
VASCULAR	
Leg cramping, muscle fatigue, aching when walking	
Buttock cramping, fatigue when walking	
Pain in feet / legs at rest	
Impotence	
Non-healing wounds	
Slow-healing wounds	
Skin discoloration on the legs or feet	
Varicose veins	
Spider veins	
PULMONARY	
Cough	
Sputum production	
CPAP / BiPAP use	
Use of home oxygen Continuous At night _____liters	
GASTROINTESTINAL	
Abdominal pain	
Black / tarry stools	
Red blood from rectum	
Nausea / vomiting	

PROBLEM	✓
GENITOURINARY	
Blood in urine	
Painful urination	
Frequent urination	
Urinary incontinence	
MUSCULOSKELETAL	
Joint pain or swelling	
Back pain	
Muscle weakness	
INTEGUMENTARY	
Rash	
Wounds	
NEUROLOGICAL	
Numbness / tingling	
Weakness	
Dizziness	
Seizures	
Poor balance	
PSYCHOLOGICAL	
Depression	
Anxiety	
Dementia	
Addiction	
ENDOCRINE	
Weight gain	
Weight loss	
Heat / cold intolerance	
HEMATOLOGIC	
Abnormal bleeding / bruising	
Blood clot(s)	
Previous chemotherapy or radiation	
HIV	
ALLERGIC / IMMUNOLOGIC	
Asthma	
Frequent infections	
Hives	
Itchiness of eyes, nose, and / or mouth	

❑ **I HAVE REVIEWED ALL ABOVE QUESTIONS AND I DO NOT CURRENTLY HAVE ANY OF THESE SYMPTOMS.**

Patient Signature: _____ Date: _____

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Effective 4/01/2017

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

If you have any questions about this notice, need to file a complaint or feel your information is not being protected, please contact:

ROWAN CARDIOLOGY
689 Sierra Rose Dr
Suite B
Reno, Nevada 89511

Office for Civil Rights
U.S. Dept. of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center
(800) 368-1019 (Option 3)
(or general questions option 7)
Fax: (202) 619-3818

All complaints must be made in writing. *You will not be penalized for filing a complaint.* **OUR OBLIGATIONS:**

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and ser-vices you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Bene its and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purpos-es, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Noti ication Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.
Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT
Individuals Involved in Your Care or Payment for Your Care. 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 health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.
YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES
The following uses and disclosures of your Protected Health Information will be made only with your written authorization:
1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.
YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.nevadavascular.com

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.