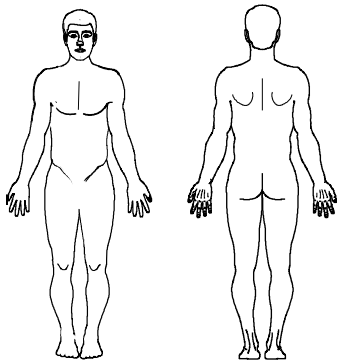
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

American Specialty Health Networks (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001

INITIAL HEALTH STATUS

(Chiropractic) Fax: 877/304-2746

Patient Name: _____ Birthdate: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Social Security #: _____ Driver Lic. #: _____

Occupation: _____ Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

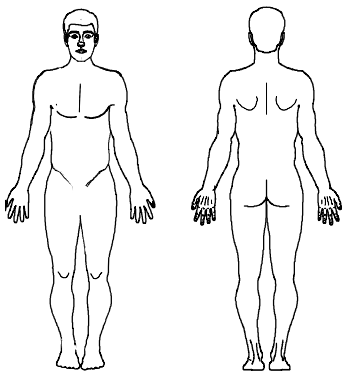
Subscriber Name: _____ Health Plan: _____

Subscriber ID #: _____ Group #: _____ Spouse Name: _____

Spouse Employer: _____ City: _____ State: _____ Zip: _____

Primary Care Physician Name: _____ PCP Phone: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began:

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date) _____
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain) _____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (explain) _____
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries _____
- ☐ Medications: _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

F.I.R.S.T. HEALTH

NAME _____ HOME PHONE _____

ADDRESS _____ BUSINESS PHONE _____

CITY _____ ZIP _____ CELL PHONE _____

BIRTH DATE _____ AGE _____ REFERRED BY _____

E-MAIL _____ @ _____ MARITAL STATUS: M D W S

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ ZIP _____

SPOUSE'S NAME _____ BUSINESS PHONE _____

SPOUSE'S EMPLOYER _____ SPOUSE'S SS# _____

PATIENT'S NEAREST RELATIVE _____ RELATIONSHIP _____

HOME PHONE _____ BUSINESS PHONE _____

OTHER DOCTOR'S SEEN FOR THIS CONDITION _____

DATE OF LAST PHYSICAL EXAM _____

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that no shows or cancellations without a 24-hours notice are charged for the office visit. Furthermore, I understand that F.I.R.S.T. HEALTH will prepare any necessary reports and forms to assist me in making collection from the insurance company and that the amount authorized to be paid directly to F.I.R.S.T. HEALTH will be credited to my account on receipt. However, I understand that, except where legally or contractually prohibited, any charges for professional services rendered will be immediately due and payable if I suspend or terminate my care and treatment. Furthermore, I understand that a $20.00 collection fee is charged to all delinquent (90 days past due) accounts.

I agree to allow F.I.R.S.T. HEALTH to forward health-related material to my personal E-Mail address.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN/SPOUSE
SIGNATURE AUTHORIZING CARE _____

DRIVERS
LICENSE# _____ SS# _____

INFORMATION TAKEN BY _____ DATE _____

F.I.R.S.T. HEALTH

HEALTH HISTORY

Who is your primary care physician? _____ Phone #: _____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Arm/Hand Pain	☐ Cold Sweats	☐ Hip Pain	☐ Nausea	☐ Pins/Needles in Legs
☐ Back Pain/Stiffness	☐ Dizziness	☐ Jaw Problems	☐ Neck pain/Stiffness	☐ Sleeping Difficulties
☐ Blurred Vision	☐ Fainting	☐ Leg/Knee Pain	☐ Nervousness	☐ Shoulder Pain
☐ Bowel /Bladder changes	☐ Fever	☐ Light Bothers Eyes	☐ Night Pain	☐ Shortness of breath
☐ Chest Pain	☐ Foot/ Ankle Pain	☐ Loss of Memory	☐ Palpitations	☐ Stomach Problems
☐ Cold Feet	☐ Headaches	☐ Loss of Smell/Taste	☐ Pins/ Needles in Arms	☐ Sudden Weight Loss

Please check to indicate if you have ever had any of the following:

☐ Allergies	☐ Breast Lump(s)	☐ Fractures	☐ Migraines	☐ Psychiatric Care
☐ Allergy Shots	☐ Cancer	☐ Gout	☐ Miscarriage	☐ Sports Injuries
☐ Anorexia/ Bulimia	☐ Chemical Dependency	☐ Heart Disease	☐ Multiple Sclerosis	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Osteoporosis	☐ Tension
☐ Arthritis	☐ Depression	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Asthma	☐ Dysmenohrrea	☐ Herniated Disc	☐ Pinched Nerve	☐ Tuberculosis
☐ Auto Accident Injury	☐ Emphysema	☐ Herpes	☐ Polio	☐ Tumors/Growths
☐ Balance Problems	☐ Epilepsy	☐ Hypertension	☐ Postural Problems	☐ Ulcers
☐ Bleeding Disorder	☐ Fatigue	☐ Kidney Disease	☐ Prostate Problems	☐ Urinary Incontinence
☐ Bowl Disorder	☐ Fibrocystic Breasts	☐ Liver Disease	☐ Prosthesis	☐ Vaginal Infections

☐ Other: _____

Are you currently under medical care? ☐ Yes ☐ No if yes, Explain _____

Please list any medications you are currently taking: _____

_____

Please list any surgeries and / or hospitalizations you have had (type & date): _____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease _____ ☐ Diabetes _____

☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a orthopedic pillow? ☐ Yes ☐ No

What is your daily/weekly intake of the following:

Caffeine/Coffee _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

*I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

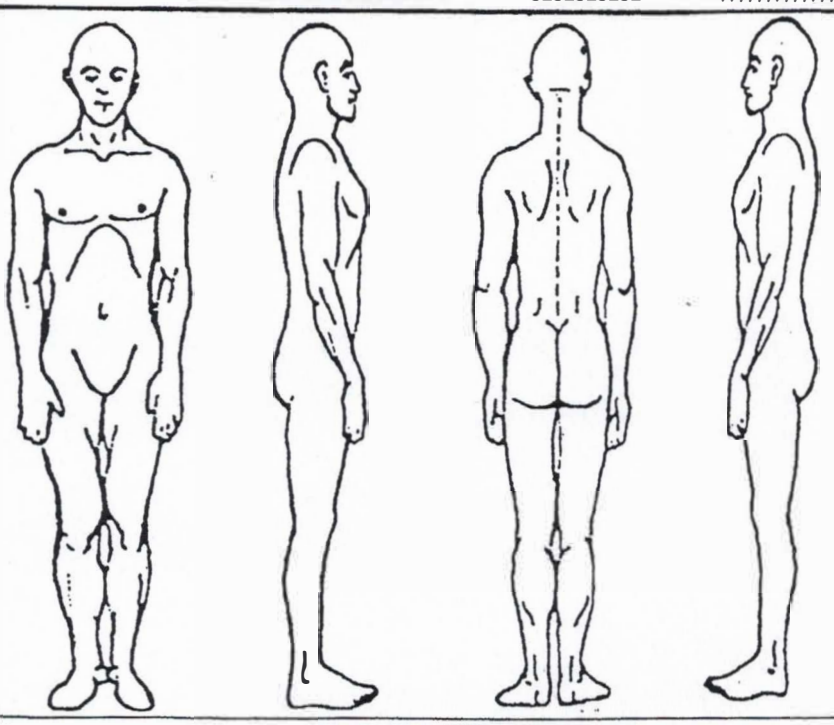
SIGNATURE: _____ DATE: _____

F.I.R.S.T. HEALTH

NAME: _____ DATE: _____

Draw location of your pain on the body outlines using the symbols below to describe your complaint.

Aching	Numbness	Pins & Needles	Burning	Stabbing & Sharp
∧∧∧∧	++++++++	0000000000000	XXXXX	//////////////////////////



Instructions: Please choose the number which best describes your pain.

What is your pain RIGHT NOW?

0	0	0	0	0	0	0	0	0	0
1	2	3	4	5	6	7	8	9	10

No Pain **Unbearable Pain**

PURPOSE OF THIS APPOINTMENT: Please mark "1" if present condition, "2" if past history of.

___Headaches/Migraines
___Neck pain
___Pain between shoulders
___Low back pain/Sciatica
___Spinal check-up for child
___Sports injury
___Auto accident/Whiplash
___Wellness/Prevention care
___Digestive disorder
___Dizziness
___Other_____

___Sinuses/Allergy
___Asthma/Allergy
___Ankle/Foot pain
___Wrist/Hand pain
___Nutritional imbalance
___Arthritis
___Numbness
___Rheumatic fever
___Cancer
___Heart trouble

ARE YOU PREGNANT? ___YES ___NO DATE OF LAST MENSTRUAL PERIOD_____

SIGNATURE: _____

F.I.R.S.T. HEALTH

CRAIG E. MORRIS, DC
Chiropractic Rehabilitation

THEODORE GEORGIS, MD
Orthopedic Surgery

19000 Hawthorne Blvd. Suite 302
Torrance CA 90503
Phone: (310) 793-9400
Fax: (310) 793-0200

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____
Name of Doctor, Clinic, Hospital, etc.

_____
Address

I_____ request the following information to be released to F.I.R.S.T. HEALTH for the purpose of review:

X-rays _____ History _____ Treatment Records _____ MRI/CT Scan(S) _____ Reports _____

A photocopy of facsimile copy of this form with your signature shall be considered as authentic as the original.

I understand the California Health and Safety Code Section 1795.12 requires the patient records be transmitted within 15 days after receiving this request.

Signed: _____ Date: _____

_____
Translator/ Witness

***CONFIDENTIALLY NOTICE**
THIS FORM IS PRIVILEGED AND CONFIDENTIAL AND IS INTENDED ONLY FOR THE REVIEW OF THE PARTY TO WHOM IT IS ADRESSED. IF YOU HAVE RECEIVED THIS FORM IN ERROR, PLEASE IMMEDIATELY RETURN IT TO THE SENDER.

F.I.R.S.T. HEALTH

19000 Hawthorne Blvd. Suite 302
Torrance, CA 90503

FINANCIAL POLICY

_____ 1. I understand that I am required to pay for all charges on the date services are rendered. Unless, I am
initial covered by a PPO or HMO-HPO health plan in which the physician is a participating provider and I am being seen for a service I know to be covered by my policy.

_____ 2. I understand the F.I.R.S.T. HEALTH accepts MasterCard/Visa/American Express/Discover and Diners, my
initial personal check, money orders or cash. If the bank returns a check payable, I will be charged a $25.00 service fee, which is due and payable along with the amount of the original check.

_____ 3. I understand and agree that if I receive a statement in the mail, the amount stating my responsibility is
initial due in 10 days.

_____ 4. If my account exceeds 90 days, I understand I am in a collection status, and a $10.00 collection fee plus a
initial finance charge equal to 1 ½% per month may be added to my account.

MEDICAL INSURANCE POLICY

_____ 1. I understand and agree that I am ultimately responsible for my account in full, even though I have medical
Initial insurance. Should there be a problem with my insurance company not paying in a timely manner or for the correct amount, I agree to pay the doctor and settle my difference with my insurance company.

_____ 2. I will pay all co-pays, deductibles or percentages due on the date of service.
initial

_____ 3. I hereby authorize payment directly to Craig E. Morris, D.C. or F.I.R.S.T. HEALTH insurance benefits
initial otherwise payable to me. I understand I am financially responsible for charges not covered by this authorization. I also authorize that a photographic copy of this authorization is as valid as the original.

_____ 4. I hereby authorize the disclosure of medical information to my stated insurance company for the purpose
Initial of obtaining payment for service rendered.

_____ 5. I will pay for all nutritional supplements, orthopedic supplies, plus any other healthcare supplies in stock,
Initial on the date they are dispensed.

_____ 6. I will pay for all custom ordered supplies in advance. I agree to pay for custom- fitted foot orthotics on the
initial day I am cast for them.

_____ 7. I understand and agree that all orthotics, appliances, supplies and supplements are not refundable or
initial exchangeable at all once they leave this office.

Print Name: _____ Date: _____ File #: _____

F.I.R.S.T. HEALTH

19000 Hawthorne Blvd. Suite 302
Torrance, California 90503

INFORMED CONSENT TO CHIROPRACTIC CLINICAL MANAGEMENT

I hereby request and consent to the performance of chiropractic clinical management, including but not limited to, examination, diagnostic x-rays, adjustment and other manual therapeutic methods (treatment by hand or instrument), physiotherapy (modalities such as ultrasound therapy), rehabilitation (exercises and training) and counseling, on me (or on the patient named below, for whom I am legally responsible) by the clinicians, their associates and employees, of the clinic.

Our clinicians employ standard examination methods, which include the following:

1: Observation: general assessment/ appraisal in various positions.
2: Inspection: Viewing/ looking at your body (for bruising, atrophy, swelling, posture, abnormal motion, etc.)
3: Auscultation: Placing a stethoscope on your skin to listen for blood pressure and body sounds.
4: Palpation: The clinician will touch you, feeling for tenderness, heat, swelling, nodules, muscle spasm, misalignment, laxity of tissues, integrity and abnormality.
5: Percussion: Tapping on bones, tendons and other tissues with a rubber reflex hammer or hands/fingers.
6: Orthopedic/ Neurological testing: Standard test to assess your neuromusculoskeletal (i.e. nerves/ muscles/ bones/ joints) system. Some tests may be uncomfortable or painful, especially if you are already in pain.

I understand, and am informed that, as in the practice of medicine, there are some risks to chiropractic treatment including, but not limited to, fracture, disc injuries, strokes, dislocation and sprains. I do not expect the clinician(s) to be able to anticipate and explain all risks and complications, and I wish to reply on the clinician(s) to exercise judgment during the course of the procedure, which the clinician feels at the time, based upon the facts then known, is in my interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below, I agree to the above named procedures. I
Intend this consent form to cover the entire course of treatment for the present, or any future condition(s) for which I (or my ward named below) seek treatment.

_____	_____
Print Patient's name	Print Guardian's name
_____	_____
Signature of Patient	Signature of Guardian
_____	_____
Witness to Signature	Translator

Date this _____ Day of _____ 20____ Original/File/Patient

F.I.R.S.T. HEALTH

Notice of Privacy Practices

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACESS TO THIS INFORMATION
***PLEASE REVIEW CAREFULLY**

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your doctor(s), our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice and any other care required by law

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, we would disclose your protected health information or, as necessary, to a home health agency that provides care to you rand/ or we may share information with hospital staff and other physician or therapist to whom you have been referred to ensure that necessary information is available to diagnose or treat you.

Payment: Your protected health information may be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a diagnostic procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operation: We may use or disclose as-needed, your protected health information in order to support the business activities of F.I.R.S.T. HEALTH. These activities include, but are not limited to, quality assessment activities, employee review activities, training of clinical staff, licensing, and conducting or arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room or back office when the doctor or staff is ready to see you. We may use or disclose protected health information, as necessary, to contact you or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directions and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the Law (and when required by the Secretary of the Department of Health and Human Services) we must disclose to you any investigations that may involve you to determine our compliance with the requirements of section 164.500

Other Permitted and Required Uses and Disclosure Will Be Made Only With Your Consent, Authorization or Agreement unless require by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosures indicated in the authorization. If, in our judgment, the breadth or extension of revoked uses is such that we can no longer adequately provide health care, get paid for our

F.I.R.S.T. HEALTH

services rendered, or conduct our business operations, we may be unable to continue proving Medical/Chiropractic care to you. You do have the right to use another Healthcare Provider.

You have the right to request and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, a criminal or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively (i.e electronically)

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us notifying our privacy officer of your complaint. **We will not retaliate against you for filing a complaint.**

The notice was published and become effective on/or before April 14, 2003

We may require by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this notice of our Privacy Practice:

Print Name	Signature	Date

F.I.R.S.T HEALTH
19000 Hawthorne Blvd. Suite 302, Torrance CA, 90503
* Phone (310) 793- 9400 * Fax (310) 793-0200

F.I.R.S.T. HEALTH

PRIVACY POLICIES AND PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

F.I.R.S.T. HEALTH has INFORMATION

F.I.R.S.T. HEALTH has adopted policies to comply with state and federal law and safeguard your personal information. During the course of treatment in this office non-public personal information is collected about you from various sources:

- Information received from you on health questionnaire or other forms;
- Information received from other health providers;
- Information received from insurance Carriers;

To protect the privacy of all patients in the course of conducting business, even if information is not shielded from disclosure by law, information will be maintained in the strictest confidence. Protected Health information will not be sold, transferred, copied, distributed or shared with any other person or companies without express consent. Access to your personal account information is restricted to the doctor and staff members. Physical, electronic and procedural safeguard and maintained that comply with federal standards to safeguard your nonpublic personal information. Your Protected Health Information is shared with outside billing service, health plans, authorized emergency personnel, and governmental agencies in accordance with applicable law or under court subpoena.

- Inspect and copy their records
- Amend health records
- Designate with whom Protected Health Information is shared
- Request restrictions on disclosure of Protected Health Information
- File a privacy violation complaint with practice's Privacy Officer

Any privacy violation complaint should be presented in writing to a staff member and will be given to the Privacy Officer. You will be advised of the outcome of your complaint and the steps taken to correct the issue

Print name: _____ Date: _____

Signature: _____

F.I.R.S.T. HEALTH • 19000 Hawthorne Blvd., #302 • TORRANCE, CA 90503
TELEPHONE (310) 793-9400 • FAX (310) 793-0200