



COMPREHENSIVE
CANCER CENTERS

LUNG CENTER OF NEVADA
A Division of Comprehensive
Cancer Centers

HEALTH HISTORY QUESTIONNAIRE

Name: _____ D. O. B.: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name and Address: _____

Medical Equipment Company (oxygen, nebulizer, CPAP, BiPAP): _____

Reason for Visit: _____

Review of Systems: Check all symptoms you've had in the past six months:

General:

- Appetite Loss
- Daytime Sleepiness
- Fatigue
- Fever
- Night Sweats
- Trouble Sleeping
- Significant Weight Gain
- Significant Weight Loss
- Unable to Sleep Lying Flat

Skin:

- Itching
- Rash

HEENT:

- Glaucoma
- Hoarseness
- Nasal Congestion
- Runny Nose

HEENT Cont:

- Seasonal Allergies
- Snoring
- Sore Throat
- Visual Loss

Respiratory:

- Cough
- Coughing up Blood
- Shortness of Breath
- Sputum Production
- Wake up Short of Breath
- Wheezing

Cardiovascular:

- Abnormal Blood Pressure
- Chest Pain
- Heart Failure
- Palpitations
- Swelling of Extremities

Gastrointestinal:

- Abdominal Pain
- Heartburn
- Nausea
- Vomiting

Musculoskeletal:

- Back Pain
- Joint Pain
- Muscle Pain

Neurological:

- Dizziness
- Headaches
- Numbness
- Seizures
- Stroke

Psychiatric:

- Depression
- Memory Loss
- Nervousness

Endocrine:

- Excessive Thirst
- Excessive Urination at Night
- Thyroid Problems

Hematology:

- Abnormal Bleeding
- Anemia
- Easy Bruising

Genitourinary:

- Menstrual Irregularities
- Prostate Problems
- Urinary Frequency
- Urinary Urgency

Past Medical Conditions: _____

Past Surgical: Date: _____ Type of Operation: _____

Allergies: List your allergies (medications, chemicals, food, etc.)

Medications: List your current prescription and non-prescription drugs or attach a list if more room is needed.

Name	Dosage	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social

Have you ever smoked? yes no

How many years have you smoked? _____

If quit, when? _____

How many packs a day? _____

Lived with someone who smokes? yes no

Exposure to second hand smoke? yes no

Exposure to toxic chemicals or substances? yes no

Alcohol use: yes no

If you used to drink, when did you stop? _____

What do you drink? _____

No. of times per week? _____

Marijuana or hard drugs use: yes no

Caffeine use: Medicine Coffee Tea Soda Foods

Amount per day? _____

Within 2 hrs of sleep?: yes no

How many hours do you sleep a night? _____

Occupation (if retired, past occupation): _____

Marital Status: Single Married Separated Widowed Divorced

Pets: yes no

Do you exercise? yes no

Travel: Date and place outside of the country in the last two years: _____

Family History

	Father	Mother	Brother	Sister	Son	Daughter
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless Legs Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Maintenance

Flu shot: When? _____

Pneumovax: When? _____

Covid Vaccine: When? _____

TB skin test: When? _____

Results: positive negative

Most Recent Tests: **Date**

Location

Chest X-Ray: _____

CT Scan: _____

Ultrasound: _____

MRI: _____

Breathing Test: _____

Sleep Test: _____

Lab Work: _____

Last Colonoscopy: _____

Last Mammogram: _____

Pregnancy: Are you currently pregnant? yes no

Other Past Medical History: _____

Sleep History

1. Do you snore? Yes No Don't know
In which position do you snore? Back only All positions
Is it worse on your back? Yes No Don't know
Do you snore if you fall asleep in a chair? Yes No Don't know
Does your snoring disturb anyone? Yes No Don't know
Has anyone ever noticed if you stop breathing in your sleep? Yes No Don't know
Do you gasp or choke while you sleep? Yes No Don't know
Does anyone sleep in your bedroom with you? Yes No
2. Do you suffer from either of the following in the morning? Dry mouth Headache
3. Do you feel sleepy during the daytime? Yes No Don't know
How many days per week? _____
What age did it start? _____
Is it worsening? Yes No Don't know
4. Have you ever had a car accident due to sleepiness? Yes No Don't know
5. Do you suffer from memory problems? Yes No Don't know
6. Do you ever "zone out"? Yes No Don't know
7. Are you more irritable lately? Yes No Don't know
8. Do you take any daytime naps? Yes No Don't know
How many per week? _____
How long do you nap? _____
Are your naps refreshing? Yes No
9. Rate the severity of your sleepiness (1 = no sleepiness and 10 = very severe sleepiness): _____
10. Do you ever have restlessness or discomfort in your legs? Yes No
When? _____
What do you do to relieve it? _____
How often does it occur? _____
Does it interfere with your sleep? Do you move or kick your legs while sleeping? Yes No
Yes No Don't know
11. Have you ever felt a sudden loss of strength while experiencing a strong emotion (ie. fear, surprise, laughter)?
 Yes No
12. Have you ever felt paralyzed when waking up or falling asleep? Yes No
13. Do you ever dream while you are falling asleep or napping? Yes No Don't know
14. Do you walk or talk in your sleep? Yes No Don't know
15. Do you ever accidentally urinate in bed? Yes No Don't know
16. Do you have nightmares? Yes No Don't know
17. Have you ever injured yourself or others while asleep? Yes No Don't know
18. What is your bedtime? _____
How long does it take you to fall asleep? _____
When do you wake up? _____
Do you wake up during the night? Yes No Don't know
How many times per night? _____ What awakens you? _____

19. Work hours (if applicable): _____

If you do not work, how do you occupy your days? _____

What do you do in the evenings? _____

20. How likely are you to doze off or fall asleep in the following situations?

0 = Would **NEVER** doze 1= **SLIGHT** chance of dozing 2 = **MODERATE** chance of dozing 3 = **HIGH** chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour, without a break	0	1	2	3
Lying down to rest in the afternoon, when circumstance permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without having had any alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3



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**LIMITED ENGLISH PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES
FOR NEVADA**

ATTENTION: If you speak any of the following languages, language assistance services, free of charge, are available to you. Call 1-877-261-6608 for more information.

<p>Amharic: ትኩረት: እርስዎ የ አማርኛ ተናጋሪ ከሆኑ የ ቋንቋ ድጋፍ አገልግሎቶች ያለ ክፍያ በነጻ ተዘጋጅልዎታል። በ1-877-261-6608 ይደውሉ።</p>	<p>Arabic ملحوظة: إذا كنت تتحدث اللغة العربية، تتوفر لك خدمة المساعدة اللغوية بالمجان. برجاء الاتصال بـ 1-877-261-6608.</p>
<p>Chinese: 注意: 如果您讲中文, 我们可以为您提供免费语言协助服务。请拨打 1-877-261-6608。</p>	<p>French: ATTENTION : Si vous parlez français, des services d'aide linguistique, vous sont proposés gratuitement. Appelez le 1-877-261-6608.</p>
<p>German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-877-261-6608.</p>	<p>Ilocano: PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan iti 1-877-261-6608.</p>
<p>Japanese: ご注意: 日本語でお話しになりたい場合は、無料の言語支援サービスをご利用いただけます。1-877-261-6608にお電話ください。</p>	<p>Korean: 안내: 한국어 통역지원서비스를 무료로 제공해드리고 있습니다. 지원이 필요하시면, 전화 1-877-261-6608로 문의하시기 바랍니다.</p>
<p>Russian: ВНИМАНИЕ: Если вы говорите по-русски, вам предложены бесплатные услуги перевода. Звоните по телефону 1-877-261-6608.</p>	<p>Samoan: FAAALIGA: Afai e te tautala Faa-Samoa, o loo maua fesoasoani mo tautua tau gagana, e lē totogia mo oe. Telefoni i le 1-877-261-6608.</p>
<p>Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llamar al 1-877-261-6608.</p>	<p>Tagalog: ATENSYON: Kung nagsasalita ka ng Tagalog, ang mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit mo. Tumawag 1-877-261-6608.</p>
<p>Thai: โปรดทราบ: หากคุณพูดภาษาไทย บริการให้ความช่วยเหลือด้านภาษาพร้อมให้บริการแก่คุณ โดยไม่มีค่าใช้จ่าย โทร 1-877-261-6608</p>	<p>Urdu: توجہ: اگر فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان در اختیارتان قرار می گیرد۔ با 1-877-261-6608 تماس بگیریں۔</p>
<p>Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Hãy gọi 1-877-261-6608.</p>	



COMPREHENSIVE
CANCER CENTERS

cccnevada.com

PATIENT ACKNOWLEDGEMENT

The undersigned patient of Comprehensive Cancer Centers of Nevada (“CCCN”) acknowledges and agrees as follows:

1. My CCCN practitioner may refer me to non-CCCN healthcare providers for services including but not limited to diagnostic testing, imaging, and/or specialist consultation (each an “Outside Provider”);
2. Outside Providers are not affiliated with CCCN, and CCCN has no control over their services;
3. CCCN is not responsible for any delays in my care or other disruptions to my diagnosis or treatment which may be caused by Outside Providers beyond CCCN’s control; and
4. CCCN is not responsible for the costs of any services provided by Outside Providers, which may or may not be covered in whole or in part by my insurance plan.

Patient Signature: _____

Date: _____

Patient Name: _____

DOB: _____

FOR CCCN USE ONLY:

Witness Signature: _____

Date: _____

Witness Name: _____

Title: _____

400 N. Stephanie Street, Suite 300 • Henderson NV 89014 • 702.952.3350

SERVICES: Medical Oncology | Hematology | Radiation Oncology | Breast Surgery | Pulmonology & Sleep Disorders
Cancer Genetic Counseling | Diagnostics | Clinical Trials & Research | CyberKnife® Radiosurgery



COMPREHENSIVE
CANCER CENTERS

LUNG CENTER OF NEVADA

A Division of Comprehensive
Cancer Centers

9280 W. Sunset Rd., Suite 312 Las Vegas, NV 89148
Phone (702) 737-5864 Fax (702) 463-7015

Authorization to Use and Disclose Protected Health Information

Patient Name: _____ DOB: _____

INFORMATION TO BE RELEASED FROM:

Name: _____ Phone Number: _____ Fax: _____

Address: _____

INFORMATION TO BE RELEASED TO:

Name: LUNG CENTER OF NEVADA Phone Number: 702-737-5864 Fax: 702-463-7015

Address: 9280 W SUNSET RD SUITE 312, LAS VEGAS, NV 89148

PURPOSE OF RELEASE: (Please Check One)

_____ Continuity of Care _____ Personal Use _____ Other: _____

INFORMATION TO BE RELEASED:

_____ All Records _____ Progress Notes _____ Sleep Studies
_____ Labs _____ Stress Test
_____ PFT _____ Echo Report
_____ CXR/CT Chest Reports
_____ Other (Specify): _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office and obtain a copy of the Privacy Notice.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN 12 MONTHS

Signature of Patient/Guardian/Representative

Date

Relationship to Patient



COMPREHENSIVE
CANCER CENTERS

Meaningful Use Update

Name: _____

Date of Birth: _____

Race/Ethnicity: _____

Preferred Language: _____

Preferred Method of Contact

Email: _____

Cell: _____

Home: _____

Other: _____

Marital Status

Married

Single

Widowed

Divorced

Life Partner



COMPREHENSIVE
CANCER CENTERS

**Using and Disclosing Protected Health Information for
Involvement in the Individual's Care and Notification Purposes**

As per the notice of privacy practices, Comprehensive Cancer Centers must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patients' family member, friends or acquaintances involved in their care.

This document will serve as a written agreement between _____ (patient) and Comprehensive Cancer Centers as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to. It will be the patient's responsibility to update as necessary.

Next of kin:

Name	Phone	Relationship
_____	_____	_____

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes / No Per My Permission – Leave medical information on my answering machine.

I hereby authorize Comprehensive Cancer Centers to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my care. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating), a family member, personal representative or another person responsible for my care, of my location and/or condition.

_____	_____	_____
Patient Signature	SS #	Date



COMPREHENSIVE
CANCER CENTERS

**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Comprehensive Cancer Centers of Nevada is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Comprehensive Cancer Centers of Nevada.

Date: _____

Name: _____

Signature: _____

Name of Personal Representative (if appropriate): _____

Signature of Personal Representative (if appropriate): _____

Comprehensive Cancer Centers of Nevada Use Only

Date acknowledgment received: _____ -OR-

Reason acknowledgment was not obtained: _____



COMPREHENSIVE CANCER CENTERS

Patient Financial Policy

We, the staff at Comprehensive Cancer Centers of Nevada, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to speak to a Patient Benefits Representative who is available in the office where your care is provided. Insurance Specialists are also available to answer questions Monday through Thursday from 8:30 AM to 5 PM at our Central Business Office at (702) 952-3350. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

Payment for our services is due at the time that those services are provided to you, and we expect that all charges we present to you at a visit will be paid at the time of the visit. This includes, among other things, co-pay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by insurance programs. We may also present charges to you by written statement or letter via the mail following a visit. If we do this, we expect that each charge will be paid in full the first time it is presented to you.

We make payment as convenient as possible. Payment may be made in person at any of our locations or by return mail, by phone call or via our payment portal at www.cccnevada.com. We accept cash, money order, MasterCard, Visa, American Express, Discover and in-state checks. A \$25 service fee will be charged for all returned checks.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

We will remind you of unpaid charges monthly by statement through the mail. If, after four statements, charges remain unpaid and you have not made payment arrangements, you may be contacted in writing or by phone by a third party. By accepting our services, you are consenting to receive these communications.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment of services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with their insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.

It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payment, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Missed Appointments

We currently do not charge for missed appointments. We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy.

Patient Name (Please Print): _____

Signature of Insured or Authorized Representative: _____

Date: _____



COMPREHENSIVE
CANCER CENTERS

NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2016

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.

About Us

In this Notice, we use terms like "we," "us," "our" or "Practice" to refer to Comprehensive Cancer Centers of Nevada, its physicians, employees, staff and other personnel. All of the sites and locations of Comprehensive Cancer Centers of Nevada follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes and for other purposes as described in this Notice.

Purpose of this Notice

This Notice describes how we may use and disclose your health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. We are also required to notify you of a breach of your unsecured health information. We will abide by the terms of this Notice.

How We May Use or Disclose Your Health Information

The following categories describe examples of the way we use and disclose health information without your written authorization:

For Treatment: We may use and disclose your health information to provide you with medical treatment or services. For example, your health information will be shared with your oncology doctor and other health care providers who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your primary care physician or another healthcare provider to be sure they have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. These uses and disclosures are necessary to run the Practice and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and

collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

Individuals Involved in Your Care or Payment for Your Care and Notification: If you verbally agree to the use or disclosure and in certain other situations, we will make the following uses and disclosures of your health information. We may disclose to your family, friends, and anyone else whom you identify who is involved in your medical care or who helps pay for your care, health information relevant to that person's involvement in your care or paying for your care. We may also make these disclosures after your death.

We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care regarding your physical location within the Practice, general condition or death. We may also use or disclose your health information to disaster-relief organizations so that your family or other persons responsible for your care can be notified about your condition, status and location.

We are also allowed to the extent permitted by applicable law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your 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.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if the victim agrees or we are unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime not occurring on our premises, the nature of a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- Activities related to the quality, safety or effectiveness of FDA-regulated products;
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition as authorized by law; and
- To notify an employer of findings concerning work-related illness or injury or general medical surveillance that the employer needs to comply with the law if you are provided notice of such disclosure.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat or as necessary for law enforcement authorities to identify or apprehend an individual.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle procurement, transplantation or banking of organs, eyes, or tissues.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to 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.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain research activities without your written authorization. For example, we might use some of your health information to decide if we have enough patients to conduct a cancer research study. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your health information without your authorization.

Other Uses and Disclosures of Your Health Information that Require Written Authorization:

Other uses and disclosures of your health information not covered by this Notice will be made only with your written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization. This would include making treatment communications to you when we receive a financial benefit for doing so.
- Sale of Your Health Information: We may sell your health information only with your written authorization.

If you authorize us to use or disclose your health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by your revocation, except to the extent that we have taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **In most circumstances, we are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing and submit it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** We are required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the service or item in question out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** You may request access to your medical information in a certain electronic form and format if readily producible or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit a copy of your health information to any person or entity you

designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you request a copy of your health information, we may charge a cost-based fee for the labor, supplies, and postage required to meet your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.**

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us that will become part of your medical record.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we make of your health information. Please note that certain disclosures need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please alert the receptionist at the front desk of any of our locations or contact **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014.** You may also obtain a paper copy of this Notice at our website, **www.cccnevada.com**.

Changes to this Notice

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the patient waiting areas at each facility. Each version of the Notice will have an effective date listed on the first page. Updates to this Notice are also available at our website, **www.cccnevada.com**.

Complaints

If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014,** or phone **(702) 952-3350.** You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against or penalized for filing a complaint.

Questions

If you have questions about this Notice, please contact **CCCN, Attn: HIPAA Privacy Officer, 400 N. Stephanie St., Henderson NV 89014,** or phone **(702) 952-3350.**