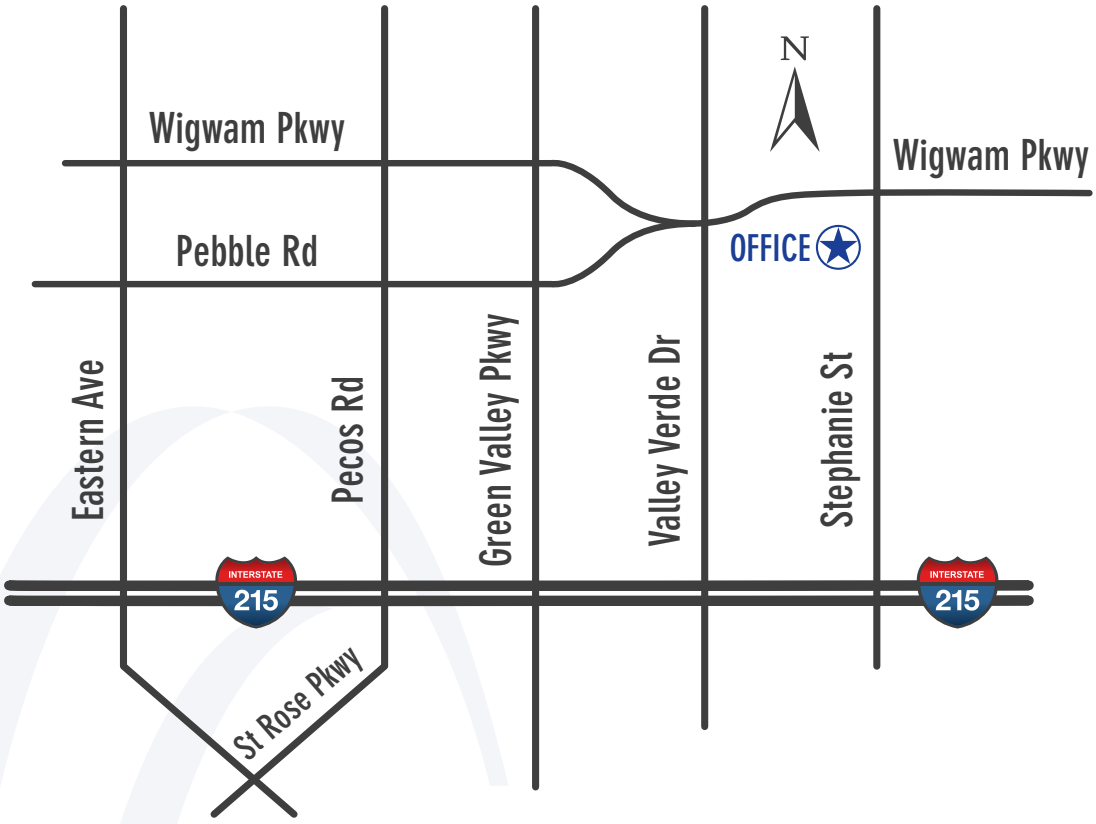
Patient MRN _____

Southeast Henderson Treatment Center



Stephani Christensen, MD
Medical Oncology • Hematology
Board Certified Internal Medicine
Board Certified Medical Oncology
Board Certified Hematology
1505 Wigwam Parkway, Suite 130
Henderson, NV 89074
Tel: 702.856.1400 • Fax: 702.856.1407

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Henderson, NV 89074
Tel: 702.856.1400 • Fax: 702.856.1407

Please Complete ALL Forms and Bring Them with You

COMPREHENSIVE CANCER CENTERS
cccnevada.com
Affiliated With The US Oncology Network

COMPREHENSIVE
CANCER CENTERS

Please do not wear any perfumes, colognes or bring strong-smelling foods when visiting our center because individuals receiving chemotherapy and/or radiation therapy are often very sensitive to odors.

Thank you for your consideration and cooperation.

COMPREHENSIVE CANCER CENTERS

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.

Amharic:	**Arabic**
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-261-6608	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن 1-877-261-6608 رقم) اتصل برقم .خدمات المساعدة اللغوية تتوافر لك بالمجان هاتف الصم والبكم: 1-877-261-6608).|
Chinese:	**French:**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-261-6608。	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-261-6608.
German:	**Ilocano:**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-261-6608.	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-877-261-6608.
Japanese:	**Korean:**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-261-6608 まで、お電話にてご連絡ください。	*주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.* 1-877-261-6608
Russian:	**Samoan:**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-261-6608.	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-877-261-6608.
Spanish:	**Tagalog:**
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-261-6608.	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-261-6608.
Thai:	**Urdu:**
เรียน ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-261-6608	ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-261-6608
Vietnamese:	
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-261-6608.	

Today's Date _____
Patient MRN _____

COMPREHENSIVE CANCER CENTERS

Patient Questionnaire

Patient Name: _____ Age: _____

Referred by: _____ Primary Care Physician: _____

OB/GYN: _____ Surgeon: _____

Other Physicians: _____

Problems that have led patient to seek medical attention here (check)?

___ Abnormal mass/lump ___ Abnormal breast mass/lump ___Abnormal scan/mammogram

___ Poor breathing ___ Cough ___ Pain ___Weight Loss ___ Abnormal Lab

Other:

_____

Medical History

Please check if you have a history of any of the following

	Yes	No			Yes	No
Heart attack				Congestive heart failure		
Kidney disease				Other heart disease		
Liver disease				High blood pressure		
Tuberculosis				Lung problems		
Seizures				Thyroid disease		
Diabetes				Phlebitis		
Emphysema/COPD				Stomach problems		
Arthritis				Skin disease		
Previous Cancer Type?				Pain: location _____ Mild: ___ Moderate: ___ Severe: ____		

Surgical History

Surgeries	Date	Surgeries	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Transfusions yes___ no___ Transfusion reaction yes___ no___

Allergies

Medication(s) = allergic reaction

1._____=_____ 2._____=_____ 3 ._____=_____

Current Medications

Medication	Dose	Frequency	Medication	Dose	Frequency
1._____			6._____		
2._____			7._____		
3._____			8._____		
4._____			9._____		
5._____			10._____		

Family History

Family Member	Living/Age	Deceased/Age	Health Status or Cause of Death
Father			
Mother			
Brothers #			
Sisters #			

Please list any other family members who have had cancer and type of cancer:

_____

_____

Social History

Are you currently: Employed Retired Unemployed On Disability

Occupation: _____

Circle one: Single Married Divorced Widowed Separated

Occupation of others in household: _____

Children: # of Sons: ____ Ages: _____ Illness: _____

# of Daughters: ____ Ages: _____ Illness: _____

Have you ever smoked? _____ If yes, your age when you started: _____

Average packs per day: _____ Date quit (if applicable): _____

Do you drink alcohol? _____ What type: _____ How much per week? _____

Did you ever drink large amounts of alcohol? _____ Date quit (if applicable): _____

GYN/OB History (women only)

Date of last menstrual period _____ Last Pap smear _____

Last mammogram _____ Last bone density/osteoporosis scan _____

Are you currently pregnant? ____ Could you possibly be pregnant? _____

Pregnancies ____ # Live births _____ Age at first pregnancy _____ Age at menopause _____

Birth control pills? Yes___ No____ Name _____ Dates _____

Fertility medicines? Yes___ No____ Name _____ Dates _____

Hormone Medicine

Replacement therapy? Yes___ No____ Name _____ Dates _____

Review of Systems

General	Yes	No			
Hot flashes			Fatigue		
Fevers			Night sweats		
Weight gain # pounds			Weight loss # pounds		
Poor appetite					

Eyes	Yes	No			
Cataracts			Double vision		
Blurred vision			Glaucoma		
Vision Loss			Floaters		

Head and Neck	Yes	No			
Mouth pain/ulcers			Post nasal drip		
Sinusitis/sinus pain			Hearing loss		
Difficulty swallowing			Hoarse voice		

Cardiovascular	Yes	No			
Chest pain			Heart murmur		
Palpitations			Ankle swelling		
Calf pain			Light headed		

Pulmonary System	Yes	No			
Cough			Shortness of breath		
Coughing blood			Pain with breathing		
C-PAP			Wheezing		
Sputum					

Gastrointestinal	Yes	No			
Nausea			Yellow skin (Jaundice)		
Vomiting			Clay colored stool		
Constipation			Blood in stool		
Diarrhea			Abdominal pain		
Vomiting blood			Black stool		
Difficulty swallowing			Heartburn		
Colonoscopy			Date of colonoscopy _____ Normal? _____		

GYN	Yes	No			
Vaginal Discharge			Vaginal bleeding		

Nervous System	Yes	No			
Headaches			History of stroke		
Dizziness			History of seizures		
Paralysis			Speech disturbance		

	Yes	No		Yes	No
Tremors					
Loss of sensation			Weakness of arm/leg		
Mental Illness			Passing out		
Tremors					

Musculoskeletal System	**Yes**	**No**		**Yes**	**No**
Arthritis			Red or swollen joints		
Bone pain			Muscle pain		
Spine pain			Arm or leg swelling		

Hematologic	**Yes**	**No**		**Yes**	**No**
Gum or nose bleeding			Treatment for anemia		
Enlarged lymph nodes			Bruising		

Genitourinary System	**Yes**	**No**		**Yes**	**No**
Pain with urination			Urgent urination		
Blood in urine			Incontinence		
Frequent urination			Night time urination _____X		

B/P: _____ T: _____ P: _____ R: _____ Wt: _____ Ht: _____ BSA: _____ O2Sat: _____

Date:_____ RN/MA: _____

Patient MRN _____

COMPREHENSIVE CANCER CENTERS

Cancer Family History Questionnaire

Please complete this form to the best of your ability and bring it to your next scheduled visit with your physician. This information will assist your physician in knowing the cancers that may run in your biological (blood related) family. When you complete the table below, please include your information as well as information for your parents, sisters, brothers, sons, daughters, grandparents, aunts, uncles, and first cousins. Please sign the form.

Date Form Completed: _____ Date of Birth: _____/_____/_____

Print Name: _____Patient's Signature: _____

Cancer Type	Who was/is affected? At what age was the cancer type found? *For Example: Dad, 45 years old Mom, 67 years old Son, 56 years old*
Ovarian	
Breast	
Uterus	
Colon/rectal	
Prostate	

Are there any other cancers that run in your family?

_____

Are you of Ashkenazi Jewish descent? ☐ **YES** ☐ **NO**

Are you of African American descent? ☐ **YES** ☐ **NO**

Have you or anyone in your blood related family had 20 or more lifetime colon polyps? ☐ **YES** ☐ **NO**

Has anyone in your family had cancer genetic testing? _____If yes, explain: _____

Are you concerned about your personal and/or family history of cancer? _____

For Healthcare Provider/Staff completion:

Recommendations: ☐ Refer for Genetic Counseling *(by MD order or physician standing order).*

☐ No Genetic Counseling referral indicated at this time.

Patient MRN _____

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	

Patient MRN _____

COMPREHENSIVE
CANCER CENTERS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date: ___/___/_____

I hereby authorize: _____

To release any and all medical records to:

_____ Stephani Christensen, MD

_____ Regan Holdridge, MD

_____ Anthony V. Nguyen, MD

Comprehensive Cancer Centers of Nevada

1505 Wigwam Parkway, Suite 130

Henderson, NV 89074

Tel: 702.856.1400; Fax: 702.856.1401

Signature: _____

DOB: ___/___/_____

Please release the following:

_____ History & Physical

_____ Last Progress Notes

_____ Mammograms

_____ All Labs

_____ Recent Diagnostic Tests

_____ Pathology

_____ Other (see below)

_____ ER, PR & DNA Tests

_____ All Requested (see attached list)

_____

_____

_____

Patient MRN _____

COMPREHENSIVE
CANCER CENTERS

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. If you do not have e-mail access, please check the box and sign at the bottom.

_____ _____
Patient Name (First Name, Middle Initial, Last Name) Date of Birth of Patient

☐ **I do not have e-mail access.** ☐ **I do not want access to the portal.**

Authorized user is:

_____
Authorized User Name (If different from patient)

- ☐ Patient
- ☐ Patient's Guardian (or parent of un-emancipated minor patient)
- ☐ Person authorized to make decisions on behalf of patient (*e.g*. by a medical power of attorney)

_____ _____
Email Address of Patient or Authorized User Physician's Name

_____ _____
Authorized Signature Date

_____ _____
Signature of Practice Staff [Confirming user's identity and authority] Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN_____
Email in PMS_____	iKM Consent_____

Patient MRN _____

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: _____
_____
_____
_____

Patient MRN _____

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

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 iidentity, 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 contractingor 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 surveillancethat 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 onlyuse 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 writtenauthorization. This would include making treatment communications to you when we receive a financialbenefit 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**.