Automobile Accident

Name/Nombre: _____
Last Name/Apellido First Name/Primer Nombre

Address/Direccion: _____Apt.#:_____

City/Ciudad: _____State/Estado:_____Zip Code:_____

Home Phone: _____
Cell Phone (number & carrier):_____Email:_____

DOB/Fecha de Nacimiento: ____/_____/_____ ( ) Single ( ) Married ( ) Divorce ( ) Widowed

SS#:_____ ( ) Female ( ) Male
Whom May We Notify In Case of Emergency? _____
Relationship:_____Tel. Number:_____

INJURY/LESIONES

Please describe where you are having pain/favor de indicar donde siente dolor:_____
_____
Have you lost days of work? ( ) Yes ( ) No if so, when:_____
_____
List any other Doctors seen for this matter:_____
Please list medication(s) presently taking:_____
Are you pregnant? ( ) Yes ( ) No, How far along?_____
Do you have any metal/plastic/implants/pacemaker in your body? ( ) Yes ( ) No, if so where?_____

INSURANCE: (Please provide **YOUR CAR INSURANCE** information)/SEGURO de Auto

Name:_____Insured's Name:_____Relationship:_____

Policy #:_____Claim #:_____Phone #:_____

ATTORNEYS INFORMATION/ABOGADO

Attorney Name:_____Phone #:_____

Address:_____Paralegal's Name:_____

Date & Time of Accident:_____( )am ( )pm location(State):_____Police Report ( ) Yes ( ) No

Where were You seated: ( ) Driver ( ) Front Passenger ( ) Rear Passenger ( ) Pedestrian (not in car)

What type of vehicle were you in? ( ) Compact Car ( ) Mid size Car ( ) Full Size ( ) Compact Truck
( ) Full Truck ( ) Mini Van ( ) Full Size Van ( ) Sm. Sport Utility ( ) Lg. Sport Utility ( ) Motorcycle
( ) Motor Home ( ) Bicycle

What type of vehicle were you struck by:_____

What was the estimated amount of damage to your vehicle? _____

What was your vehicle doing just prior to the accident? ( ) Stopped at a red light ( ) Slowing down to a Stop( )
At a complete Stop ( ) Increasing Speed ( ) Merging into Traffic ( ) Changing Lanes ( ) going at speed limit.

Type of seat belt?
( ) Shoulder and lap / De hombro y cintura ( ) Lap / Cintura
( ) Shoulder / Hombro ( ) None / Ninguno

Did the airbags deploy? / Se exploto la bolsa de aire? ( ) Yes / Si ( ) No / No

Where were you hit? / Donde fue el impacto?
( ) Rear / Atras ( ) Front / Adelante
( ) Driver Side / A el lado de el chofer ( ) Passenger Side / A el lado de el pasajero.

Where were you looking? ( ) Straight Ahead / Directo hacia adelande ( ) Left / Izquierda
( ) Right / Derecha ( ) Down / Hacia abajo ( ) Up / Hacia arriba

Were were you thrown? / Hacia donde fue aventado? ( ) Forward / Hacia adelante
( ) Backward / Hacia atras ( ) Side to Side / Para los dos lados

Did you strike against something within the vehicle? / Se golpio contra algo dentro de el vehiculo?
( ) Dashboard / Tablero ( ) Steering Wheel / Volante ( ) Door / Puerta ( ) Windshield / Parabrisas ( ) Head Rest / Cabecera ( ) Other / Otra parte de el auto_____

Did you have any / Tiene alguna? ( ) Yes / Si ( ) No
( ) Cuts / Cortadas ( ) Bruises / Moretones ( ) Scrapes / Raspones

Were you unconscious at he scene of the accident / Perdio ud el conocimiento en el momento de el accidente? ( ) Yes / Si ( ) No

Check the symptoms you experienced / Indique lo que sintio? ( ) Confusion ( ) Nausea
( ) Disorientation ( ) Light Headed / Desmayo ( ) Dizziness / Mareo ( ) Blurred Vision / Vista borrosa ( ) Double Vison / Doble Vision ( ) Ringing and Buzzing in the ears / Silvido en los oidos

Are you currently suffering from any of the following / Indique lo siente ahora?
( ) Restlessness / Inconformidad ( ) Difficult concentrating / Dificultad de concentracion
( ) Sleeplessness / No poder dormir ( ) Difficulty with memory / Dificultad con la memoria
( ) Forgetfulness / Se le olvidan las cosas ( ) Trouble parking the car / Problema para estacionar el auto
( ) Irritability / Irritable ( ) Jaw Pain / Dolor de mandibula ( ) Trouble controlling emotions / Dificultad en controlar sus emociones

Where did you feel pain immediately after the accident / Donde sintion dolor inmediatamente?_____
_____

Where did you feel pain after the accident / Donde sintion dolor despues?_____
_____

Where did you go after the accident / Donde fue ud despues de el accidente? ( ) Hospital
( ) Home / Casa ( ) Other / Otro lugar_____

How did you get to the Hospital / Como llego a el Hospital? ( ) Ambulance ( ) Hellicopter ( ) Friend / Amigo ( ) Parent / Padres ( ) Self / Solo ( ) Other / Otro_____

At the Hospital were you / Que le hicieron en el Hospital? ( ) X rays / Radiografia
( ) Neck collar / Collar cervical ( ) Medication / Medicamento ( ) Other /Otro_____

Name of the doctor who treated you / Nombre de el doctor que lo atendio.
_____

List your complaints, starting with the most severe / Indique sus quejas, empiece por lo mas grave._____
1._____4._____7._____
2._____5._____8_____
3._____6._____9._____

What aggravates the pain / Que empeora el dolor? ( ) Walking / Caminar ( ) Standing / Estar parado ( ) Lifting / Levantar algo ( ) Turning / Voltear ( ) Sitting / Estar sentado ( ) Lying down / Estar acostado ( ) Working / Trabajar ( ) Playing sports / Jugar deportes ( ) Bending / Agacharse

What makes you feel better / Que hace mejorar su dolor? ( ) Rest / Descansar
( ) Medication / Medicamento ( ) Ice pack / Bolsa de Hielo ( ) Hot showers / Baňos calientes ( ) Bed rest / Descanso total

Past History / Historial.

I have / Si he estado ( ) Have not / Nunca he estado been involved in another auto accident / Envuelto en otro accidente de auto. If yes, when / Si contesto si, cuando :_____

( ) I have ( ) Have not been involved in another type of accident / ( ) Si o ( ) No he estado envuelto en otra clase de accidente. If yes, when / Si contesto si, cuando :_____

Family History / Historial Familiar

Mother / Madre: ( ) Good Health / Buena Salud ( ) Poor Health / Mal estado de Salud
( ) Cause of death / Causa de Muerte:_____

Father / Padre: ( ) Good Health / Buena Salud ( ) Poor Health / Mal estado de Salud
( ) Cause of death / Causa de Muerte:_____

How did you hear about us? _____

Agreement

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Should it be necessary to take action to collect any amount owing under this agreement. I will be responsible for all attorneys, collection fees, and any other cost incurred in collecting the amount owed.

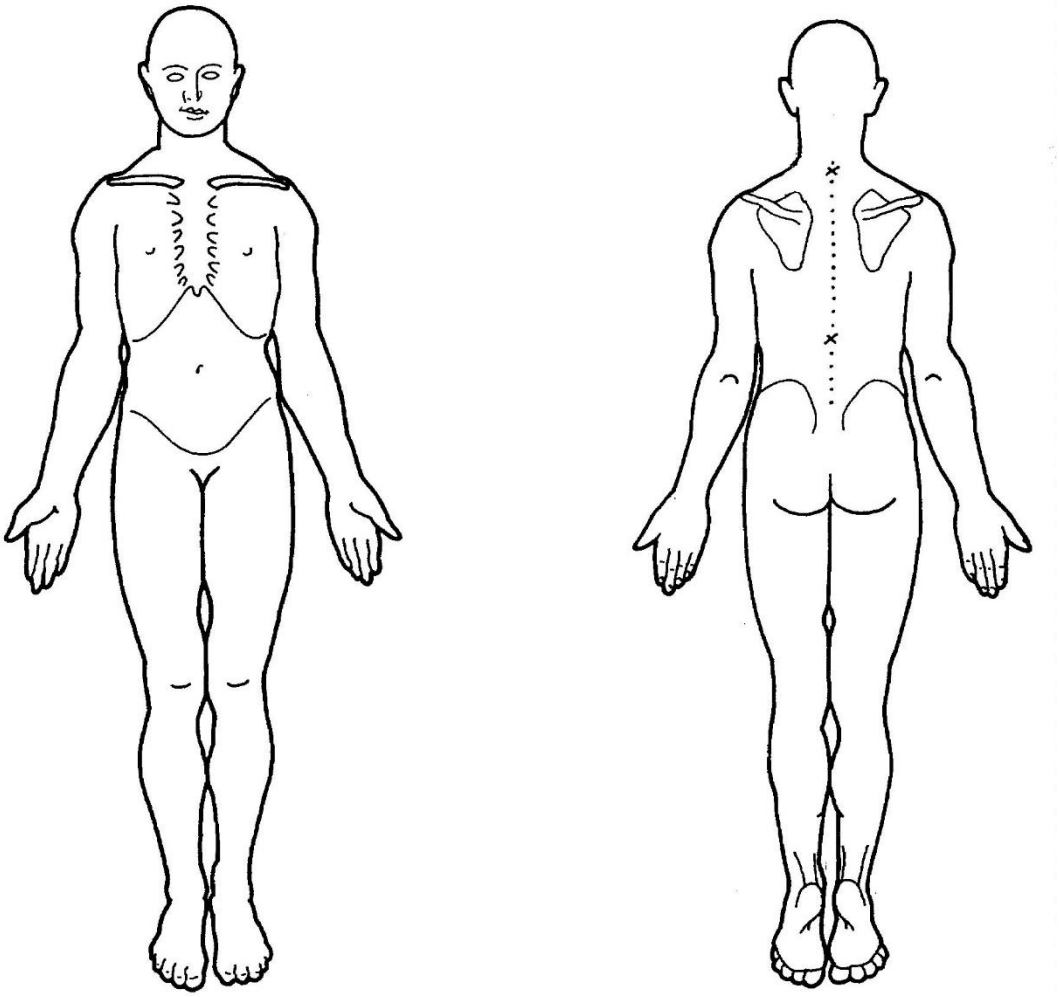
X_____ _____

Patient Signature (Parent/Guarding if Minor) Date

Acct#: _____ Name:_____Date:_____

Mark (X) on the picture where you feel pain

Marque (X) donde siente dolor



What does your pain feel like? Please check all that apply.

( ) Stiffness ( ) Ache ( ) Numbness ( ) Tingling

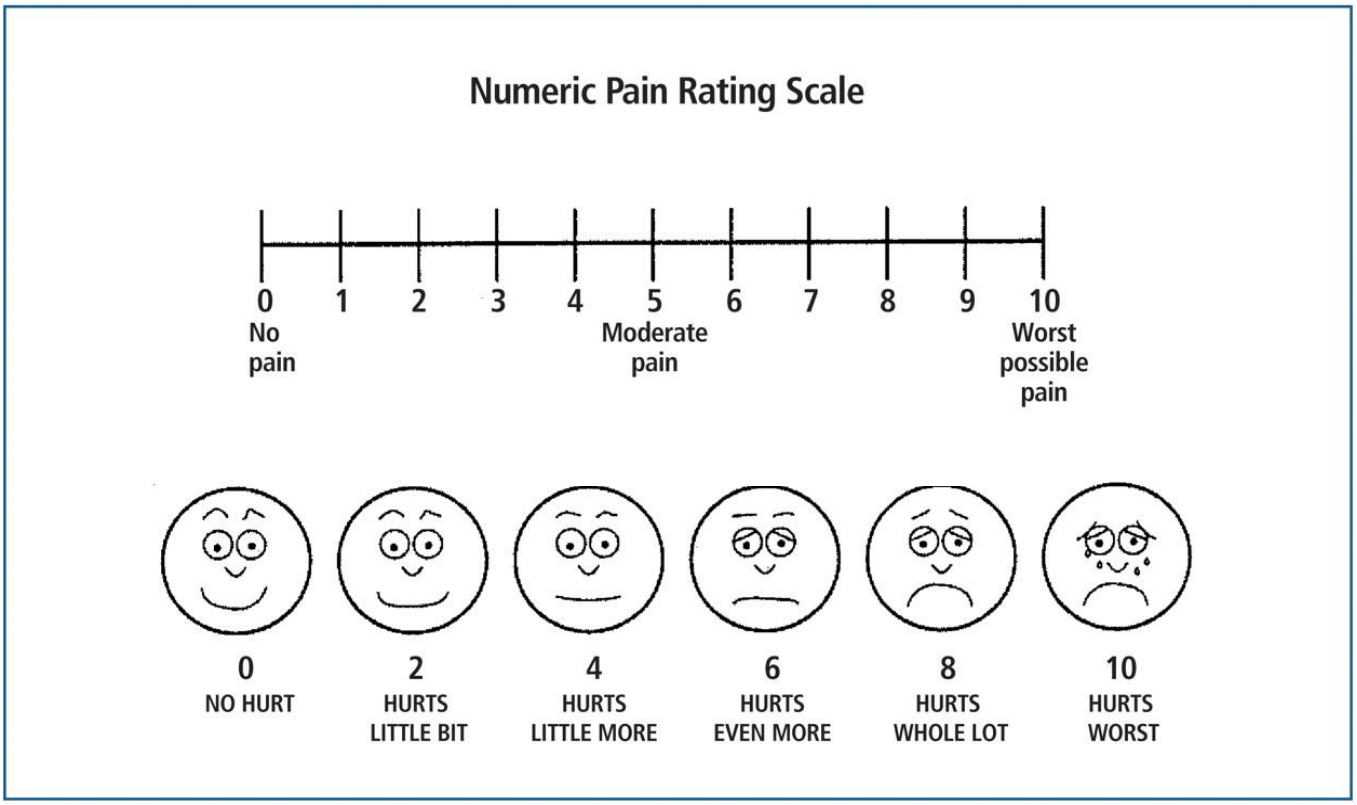
( ) Burning ( ) Stabbing ( ) Pins/Needles

Patient's Signature _____ Date_____

Patient Name:_____ Date:_____

Please indicate how much pain you have:

In order to check how your treatment is progressing – your Doctor will often ask you to rate your pain level on this diagram/scale from Zero **(0)** to Ten **(10)**. A rating of Zero **(0)** means you feel **NO pain**; five **(5)** means you feel a **moderate** amount of pain and ten **(10)** means you feel the **sever/worse** pain imaginable. **PLEASE CIRCLE THE NUMBER, YOU FEEL THAT BEST DESCRIBE YOUR PAIN LEVEL**



Por favor indicar cuanto dolor esta sintiendo:

De manera que nosotors sepamos cuanto mejoramiento usted ha tenidoen su tratamiento – el Doctor le va a pedir que califique cuanto dolor usted esta sintiendo. En este diagrama usted tiene que calificar su dolor en un vivel de cero (0) al diez (10). Si usted califica zero (0) indica que **no tiene dolor**, cinco (5) indica que tiene dolor **moderado** y diez (10) que tiene un dolor **insoportable**. **FAVOR DE CIRCULAR EL NUMERO INDICADO.**

_____ _____

Patient's Signature Date

PAINFREE CHIROPRACTIC & REHAB
6121 Lincolnia Road, Suite 100
Alexandria, VA 22312
Tel: 703-270-9020
Fax: 703-270-9016

NOTICE: AUTOMOBILE ACCIDENT PATIENTS
(Addendum to Assignment of Benefits Form)

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving to your health care provider the right to receive some or all of the payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: As long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network, your healthcare provider may bill its full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. **You are not required to sign/initial this form to receive care. However, if you do not sign this form, you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.**

By signing below, I acknowledge that I have read or had the opportunity to read this notice.

Patient Signature:_____

Date:_____

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between _____ ("Patient") and Painfree Chiropractic & Rehab ("Health Care Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the Patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care Provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care Providers right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients claim against the individual or entity whose negligence is alleged to have caused Patients injuries.

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice. Acknowledged:_____(patient initials)

Witness the following signatures and seal as of the indicated date:

Patient

Patients Signature_____

Printed Name_____

Date_____ SS#_____

Witness_____

Health Care Provider

Painfree Chiropractic & Rehab

Eden Wubante, D.C._____

Date_____

ASSIGNMENT AND AUTHORIZATION LIEN

From: *Painfree Chiropractic & Rehab*
6121 Lincolnia Rd, Suite 100
Alexandria, VA 22312
Tel: (703)270-9020 Fax: (703)270-9016

Attorney: _____
_____
_____
_____

Patient's Name: _____

Date of Accident: _____

I do hereby authorize the above clinic to furnish you, m**y** attorney with a full report of this examination, diagnosis, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, attorney, to pay directly to Painfree Chiropractic & Rehab, 6121 Lincolnia Rd Suite 100, Alexandria VA 22312 such sums as may be due and owe for medical services rendered to me both by reason of this accident and by reasons of any other bills that are due and to withhold such sums from any settlement, Judgment or Verdict as may be necessary to adequately protect said clinic against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney or myself as the results of the injuries for which I have been treated or injures in connection therewith.

I fully understand that I am directly and fully responsible to pay Painfree Chiropractic & Rehab for all medical bills submitted by this clinic for services rendered to me and that this agreement so is made solely of said Painfree Chiropractic & Rehab additional protection and in consideration of there is a waiting of payments. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover paid FEE.

Patient's Signature: _____ **Date:** _____

The undersign being attorney of record for the above patient does herby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

Attorney's Representative: _____

Attorney's Signature: _____**Date:**_____

Painfree Chiropractic & Rehab
6121 Lincolnia Road, Suite 100
Alexandria, VA 22312
703.270.9020

TERM OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such case, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social wellbeing, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease. We diagnose vertebral subluxation and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic examination, if there are unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. **OUR ONLY PRACTIC OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office gave been answered to my complete satisfaction.
I therefore accept Chiropractic care on this basis.
Signature: _____ **Date**:_____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.
Signature: _____ **Date**: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Signature: _____ **Date**: _____

NOTICE OF PRIVACY PRACTICES

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

The Practice(the "practice"), in accordance with the Federal Privacy Rule,45 CFR oarts 160 and 164(the "Privacy Rule") and applicable state laws, is committed to maintaining the privacy of your protected health information("PHI") . PHI includes information about your health condition and the care treatment you receive from the Practice and is often referred to as your health care of medical record. This Notice explains how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

(a)Treatment – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan. (b) **Payment- – To get paid for** services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including, insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment time.

(c)Health Care Operations – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

Other EXAMPLES OF HOW the Practice May Use Your PHI:(a) Advice of Appointment and Services – from time to time, contact you to provide appointment reminders. The following appointment reminders may be used: a) a postcard mailed to you at the address provided by you; and b) telephoning your home/ leaving a message on your answering machine or with who answers the phone. (b) Directory/Sign-In Log – we maintain a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices. © **Family/Friends**- The practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care. We may also use or disclose your PHI to notify or assist in the notification(including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply: i) if you are present at or prior to the use or disclosure of your PHI, the practice may use or disclose your PHI if you agree, or if the practice can reasonably infer from the circumstances, based on the exercises of its professional judgement, that you do not object to the use or disclosure.(ii) If you are not present, the practice will, in the exercise of professional judgement, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

(a)De-identified Information –health information that may be related to your care but does not identify you and cannot be used to identify you. **b)Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance information. **©Personal Representative** –to a person who, under applicable law, has the authority to represent you in making decisions related to your health care . **d) Emergency Situations** –for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PIII to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation. **(e)Public Health Activities**–when required by law to provide information to a public health authority to prevent or control disease. **(f)Abuse, Neglect or Domestic Violence** –when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.**g)Health Oversight Activities** – We may use and disclose PHI when required by law to provide info. in criminal investigations, disciplinary actions, or other activities relating to the community's health care system.**(h)Judicial and Administrative Proceeding** –in response to a court order or a lawfully issued subpoena. **(i)Law Enforcement Purposes** –, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena,or if the Practice believes that your death was the result of criminal conduct.**(j)Coroner or Medical Examiner** –to a coroner or medical examiner for the purpose of identifying you or determining your cause of death. **k)Organ, Eye or Tissue Donation** – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.**(l)Research** – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.**m)Avert a Threat to Health or Safety** – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or **the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat .(n)Specialized Government Functions** –when authorized by law with regard to certain military and veteran activity. **o)Workers' Compensation** – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system. **p) National Security and Intelligence Activities** –to authorized governmental officials with necessary intelligence information for national security activities **(q)Military and Veterans** –if you are a member of the armed forces, as required by the military command authorities. Authorization

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:(a)Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer(b)Request special restrictions on certain uses and s disclousures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522

(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510 (b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. (c)Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests. d)Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.(e)Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.(f)Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred. (g)Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer. (h)Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights(as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows: **Name: Mohammad Yousefi at 9200 Colesville Road Silver Spring, MD 20910 Phone#: 301-585-3200**

PRACTICE'SREQUIREMENTS

a)Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
(b)Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
(c) The practice is required to abide by the terms of this Privacy Notice
d)Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
e)Will distribute any revised Privacy Notice to you prior to implementation.
(f)Will not retaliate against you for filing a complaint.

Effective Date This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient's Signature _____ Date _____