PATIENT INFORMATION

PATIENT NAME: LAST FIRST M.I.	SOCIAL SECURITY NUMBER:
MAILING ADDRESS: STREET OR P.O. BOX APT	DOB: | AGE: | GENDER: FEMALE ☐ MALE ☐
CITY STATE ZIP CODE	HOME PHONE: | CELL PHONE:
PATIENT EMPLOYER:	WORK PHONE:
EMAIL ADDRESS:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ PARTNER
RACE: ☐ CAUCASIAN ☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ PACIFIC ISLANDER ☐ OTHER	ETHNICITY: HISPANIC ☐ NON-HISPANIC ☐

PHARMACY NAME:	PHARMACY PHONE:	PHARMACY ADDRESS:

RESPONSIBLE PARTY INFORMATION

IF PERSON RESPONSIBLE FOR PAYMENTS IS DIFFERENT FROM PATIENT, THEN COMPLETE BELOW:
IF PATIENT IS CHILD, PLEASE INDICATE IF PARENTS ARE: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

RESPONSIBLE PARTY NAME: LAST FIRST M.I.	SOCIAL SECURITY NUMBER:
MAILING ADDRESS: STREET OR P.O. BOX APT	DOB: | AGE: | GENDER: FEMALE ☐ MALE ☐
CITY STATE ZIP CODE	HOME PHONE: | CELL PHONE:
RESPONSIBLE PARTY EMPLOYER:	WORK PHONE:

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN:	PHONE:	DID HE/SHE REFER YOU? YES ☐ NO ☐
REFERRING PHYSICIAN (IF NOT REFERRED BY PCP):		PHONE:

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY:	RELATION:	PHONE:

WORK-RELATED INJURY

IS THIS A WORK-RELATED INJURY: YES ☐ NO ☐	IF YES, DATE OF INJURY:	CARRIER:
CLAIM #:	ADJUSTER:	PHONE:

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME:		INSURANCE NAME:	
POLICY/ID #:		POLICY/ID #:	
GROUP/ACCOUNT #:		GROUP/ACCOUNT #:	
CARDHOLDER'S NAME:		CARDHOLDER'S NAME:	
DOB:	SSN:	DOB:	SSN:
EMPLOYER:		EMPLOYER:	

ASSIGNMENT OF BENEFITS

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that while Agave Foot Specialists contract with many insurance companies, it is MY responsibility to verify with my plan that the physician I am seeing is a participating provider. I further understand that Agave Foot Specialists will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Agave Foot Specialists to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am financially responsible for all charges regardless of insurance coverage. I authorize payment of medical benefits to Agave Foot Specialists.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:	DATE:

PATIENT NAME:	DOB:	AGE:

PAST MEDICAL HISTORY

☐ ANXIETY	☐ CORONARY ARTERY DISEASE	☐ HIGH BLOOD PRESSURE	☐ NEUROLOGICAL PROBLEM
☐ ARTIFICIAL JOINT (S)	☐ DEPRESSION	☐ HIGH CHOLESTEROL	☐ OSTEOARTHRITIS
☐ ARTIFICIAL HEART VALVE (S)	☐ DIABETES ☐ TYPE 1 ☐ TYPE 2	☐ HIV/AIDS	☐ PROSTATE CANCER
☐ ASTHMA	☐ EYE PROBLEMS	☐ THYROID PROBLEMS	☐ RADIATION/CHEMO TREATMENT
☐ ATRIAL FIBRILLATION	☐ FIBROMYALGIA	☐ LEUKEMIA	☐ RENAL DISEASE
☐ BLEEDING DISORDER	☐ GERD/REFLUX	☐ LIVER DISEASE	☐ RHEUMATOID ARTHRITIS
☐ BLOOD CLOTS/PHLEBITIS	☐ GOUT	☐ LUNG CANCER	☐ SEIZURES
☐ BREAST CANCER	☐ HEADACHES	☐ LUNG DISEASE	☐ SKIN CONDITION
☐ CHEMICAL DEPENDENCY	☐ HEARING PROBLEMS	☐ LYMPHOMA	☐ STOMACH ULCERS
☐ COLON CANCER	☐ HEPATITIS TYPE: ☐ A ☐ B ☐ C	☐ MENTAL HEALTH DISORDER	☐ STROKE
OTHER:		OTHER:	
OTHER:		☐ NONE	

FOR WOMEN:	ARE YOU CURRENTLY PREGNANT OR PLANNING PREGNANCY? ☐ YES ☐ NO	ARE YOU BREASTFEEDING? ☐ YES ☐ NO

REVIEW OF SYSTEMS
(Are you currently experiencing or have you had any of the following within the last 30 days? Check all that apply)

GENERAL:	☐ NONE	☐ FEVER ☐ CHILLS ☐ NIGHT SWEATS ☐ FATIGUE ☐ WEIGHT GAIN ☐ WEIGHT LOSS ☐ POOR APPETITE
EYES:	☐ NONE	☐ BLINDNESS ☐ CHANGE IN VISION ☐ INFLAMMATION ☐ POOR VISION
EAR/NOSE:	☐ NONE	☐ HEARING LOSS ☐ RINGING IN EARS ☐ NOSEBLEEDS ☐ HOARSENESS ☐ BLEEDING GUMS
RESPIRATORY:	☐ NONE	☐ COUGH ☐ WHEEZE ☐ SHORTNESS OF BREATH ☐ COUGHING UP BLOOD
HEART:	☐ NONE	☐ ABNORMAL EKG ☐ CHEST PAIN ☐ SHORTNESS OF BREATH ☐ IRREGULAR HEARTBEAT ☐ PALPITATIONS
GI:	☐ NONE	☐ ABDOMINAL PAIN ☐ NAUSEA ☐ VOMITING ☐ BLOOD IN STOOL ☐ BLACK STOOLS ☐ HEARTBURN ☐ DIARRHEA ☐ CONSTIPATION ☐ TROUBLE SWALLOWING
URINARY:	☐ NONE	☐ BLOOD IN URINE ☐ FREQUENCY ☐ PROSTATE OR TESTICULAR PROBLEM ☐ HEAVY MENSTRUATION
MUSCLE:	☐ NONE	☐ BACK PAIN ☐ MUSCLE PAIN ☐ DISC PROBLEMS ☐ ARTHRITIS ☐ SWOLLEN JOINTS ☐ JOINT STIFFNESS
SKIN:	☐ NONE	☐ RASH ☐ ITCHING ☐ TATTOOS ☐ SKIN INFECTIONS ☐ RECURRENT BOILS ☐ DRY, SCALY SKIN
NEUROLOGIC:	☐ NONE	☐ HEADACHES ☐ SEIZURES ☐ CHRONIC NUMBNESS ☐ DIZZINESS ☐ WEAKNESS IN ARMS/LEGS ☐ TREMORS
PSYCHIATRIC:	☐ NONE	☐ DEPRESSION ☐ ANXIETY ☐ ABNORMAL SLEEP
HEMATOLOGIC:	☐ NONE	☐ EASY BRUISING ☐ BLOOD CLOTS ☐ TRANSFUSIONS ☐ SICKLE CELL DISEASE ☐ ANEMIA
ENDOCRINE:	☐ NONE	☐ GOITER ☐ THYROID PROBLEMS ☐ DIABETES ☐ DIALYSIS

PAST SURGICAL HISTORY
(Please list all past surgeries and/or hospitalizations)

DATE	TYPE OF SURGERY/REASON FOR HOSPITALIZATION	DATE	TYPE OF SURGERY/ REASON FOR HOSPITALIZATION

MEDICATIONS (Please list all current prescriptions, OTC medications and herbal supplements)

MEDICATION	DOSE/FREQUENCY	MEDICATION	DOSE/FREQUENCY
1.		4.	
2.		5.	
3.		6.	

ALLERGIES

☐ NONE	☐ CODEINE	☐ LATEX	☐ OPIOID ANALGESICS
☐ ADHESIVE TAPE	☐ CORTISONE	☐ LOCAL ANESTHETIC	☐ PENICILLIN
☐ ASPIRIN	☐ DEMEROL	☐ IODINE/SHELLFISH	☐ SULFA
OTHER:		OTHER:	
REACTION:			

FAMILY HISTORY (Check all family history conditions that apply)

☐ BLOOD CLOTS	☐ DIABETES	☐ HEART DISEASE	☐ KIDNEY DISEASE	☐ OSTEOPOROSIS	☐ SEIZURES
☐ CANCER	☐ GOUT	☐ HYPERTENSION	☐ LIVER DISEASE	☐ RHEUMATOID ARTHRITIS	☐ STROKE

MOTHER	☐ ALIVE	☐ DECEASED	AGE:	MEDICAL PROBLEMS:
FATHER:	☐ ALIVE	☐ DECEASED	AGE:	MEDICAL PROBLEMS:
SIBLING:	☐ ALIVE	☐ DECEASED	AGE:	MEDICAL PROBLEMS:
SIBLING:	☐ ALIVE	☐ DECEASED	AGE:	MEDICAL PROBLEMS:
SIBLING:	☐ ALIVE	☐ DECEASED	AGE:	MEDICAL PROBLEMS:

PATIENT NAME:	DOB:	AGE:

SOCIAL HISTORY

OCCUPATION:	
HIGHEST LEVEL OF EDUCATION:	☐ HIGH SCHOOL/GED ☐ UNDERGRADUATE ☐ GRADUATE ☐ POSTGRADUATE
TOBACCO USE?	☐ CURRENT (___________ PACKS PER DAY FOR ____________ YEARS) ☐ QUIT (YEAR ___________) ☐ NEVER
ALCOHOL USE?	☐ CURRENT (TYPE: ___________________ / AMOUNT: ___________________ / FREQUENCY: ___________________) ☐ QUIT (YEAR ___________) ☐ NEVER
RECREATIONAL DRUG USE?	☐ YES ☐ NO FREQUENCY: _______________________ HISTORY OF ALCOHOL OR DRUG ABUSE? ☐ YES ☐ NO
DO YOU EXERCISE?	☐ NEVER ☐ RARELY ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES PER WEEK ☐ DAILY
DO YOU LIVE ALONE?	☐ YES ☐ NO WHO LIVES WITH YOU?
DO YOU HAVE CHILDREN?	☐ YES ☐ NO HOW MANY?

PODIATRIC HISTORY

HEIGHT:	WEIGHT:	SHOE SIZE:

REASON FOR VISIT:	
LOCATION OF PAIN/PROBLEM:	
HOW LONG AGO DID THIS PROBLEM FIRST START?	___________ ☐ DAYS / ☐ WEEKS / ☐ MONTHS / ☐ YEARS
DID YOUR PAIN OR PROBLEM:	☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME
HOW WOULD YOU DESCRIBE YOUR PAIN?	☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER:
RATE YOUR PAIN ON A SCALE FROM 0 TO 10:	(NO PAIN) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (WORST PAIN POSSIBLE)
SINCE YOUR PAIN OR PROBLEM BEGAN, HAS IT:	☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED
WHAT MAKES YOUR PAIN/PROBLEM FEEL WORSE?	☐ RUNNING ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES ☐ RESTING ☐ DRESS SHOES ☐ HIGH HEELS ☐ FLAT SHOES ☐ ANY CLOSED TOED SHOE ☐ OTHER:
WHAT MAKES YOUR PAIN/PROBLEM FEEL BETTER?	
WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?	
HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?	
HAVE YOU EVER BEEN TO A PODIATIRST BEFORE?	☐ YES ☐ NO IF YES, PLEASE LIST NAME: LAST VISIT:

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN:	IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT:
SIGNATURE OF PATIENT, PARENT OR GUARDIAN:	DATE:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice of Privacy of Practices.

______________________________	______________________________
Patient Name (Please Print)	*Parent or Authorized Representative (if applicable)*
______________________________	______________________________
Signature	*Date*

I authorize the release of medical information/test results to the following person(s) other than myself:

Name:	**Relationship:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I authorize Agave Foot Specialists to leave information/test results on my voicemail and/or answering machine at the following contact numbers:

☐ Home: ____________________ ☐ Cell: ____________________ ☐ Work: ____________________

______________________________	______________________________
Signature	*Date*

PATIENT FINANCIAL OBLIGATION AGREEMENT

I, ____, understand that I am obligated financially for the
(Please print patient name or responsible party name)
following:

__________ co-pays and deductibles at the time of my appointment(s).
(Initial)

__________ $25.00 charge for any missed appointment(s) and/or appointments, which are not cancelled 24 hours
(Initial) prior to my scheduled appointment time.

__________ $20.00 returned check fee.
(Initial)

__________ In the event my account gets turned over to a collection agency, I will be responsible for all
(Initial) collection fees added to my balance owed.

__________ If a request for FMLA/Disability paperwork to be completed, I understand there is a fee associated
(Initial) with the request of $20.00 for the first page PLUS $5.00 per additional page. (Please see posted NOTICE at reception desk)

__________ I understand, as per ARS 12-2295 there may be a fee for request of medical records as follows:
(Initial) $25.00 clerical fee plus postage and $0.25 per page.

______________________________________ ______________________________________

Signature of Patient or Responsible Party *Date*

NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or

disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Sale of Health Information: We will not sell or exchange your health information for any type of financial remuneration without your written authorization.

Fundraising Communications: We may use or disclose your health information for fundraising purposes, but you have the right to opt-out from receiving these communications.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. If we are paid by a third party to make marketing communications to you about their products or services, we will not make such communications to you without your written authorization. Except, as stated above, no other marketing communications will be sent to you without your authorization.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **25¢** for each page, **$15.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: **Phoebe Garde** Telephone: **623-322-5501** Fax: **623-322-8996**

Address: **Agave Foot Specialists, PLLC 16841 N. 31st Ave. Suite 134, Phoenix, AZ 85053**