



Please check location of visit:
 Casa Grande Scottsdale
 Sun City Sun City West

PATIENT PROFILE

Patient Information

Patient Name: _____ Date of Birth: _____ SSN: _____
Marital Status: Married Single Sex: Male Language: English Spanish Religion: _____
 Divorced Widow Female Other _____
Primary Address: _____ apt, street _____ city _____ state _____ zip
Alternate Address: _____ apt, street _____ city _____ state _____ zip
Phone Numbers: Home _____ Cell _____ Work _____
E-Mail _____ Preferred Contact Method: _____
How did you hear about us? Physician Referral Family/Friend Insurance Internet Media Ad
Race/Ethnicity: Asian Black/African American Caucasian Native American Other: _____ Decline

Referring Physician and Primary Care Provider (PCP) Information

What provider referred you to our clinic today? Name: _____
Address: _____ Phone: _____
Who is your primary care provider (PCP)? Name: _____
Address: _____ Phone: _____

Employment Information

Occupation: _____ Employment Status: _____
Employer Name, Address & Phone: _____

Guarantor Information (if not self, please complete)

Name: _____ Relationship to Patient: _____ Date of Birth: _____ SSN: _____
Address: _____ apt, street _____ city _____ state _____ zip
Phone: Home _____ Cell _____ Work _____

Additional Information

Pharmacy Name: _____ Pharmacy Address: _____
Pharmacy Phone: _____ Prescription Plan: _____
Enrolled in Hospice? Yes No If yes, name and phone of Hospice: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____ Date of Birth: _____ SSN: _____
Address: _____ apt, street _____ city _____ state _____ zip
Phone: Home _____ Cell _____ Work _____

Name: _____ Birthdate: _____

Medications ***Please bring all medication list or bottles with you to your first appointment!***

Prior Cancer Treatment

Have you ever had cancer, or do you now have cancer? Yes No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:

Pain Assessment

Do you have pain now? Yes No Have you had pain in the past week? Yes No

If yes, please describe: _____ When did it start? _____

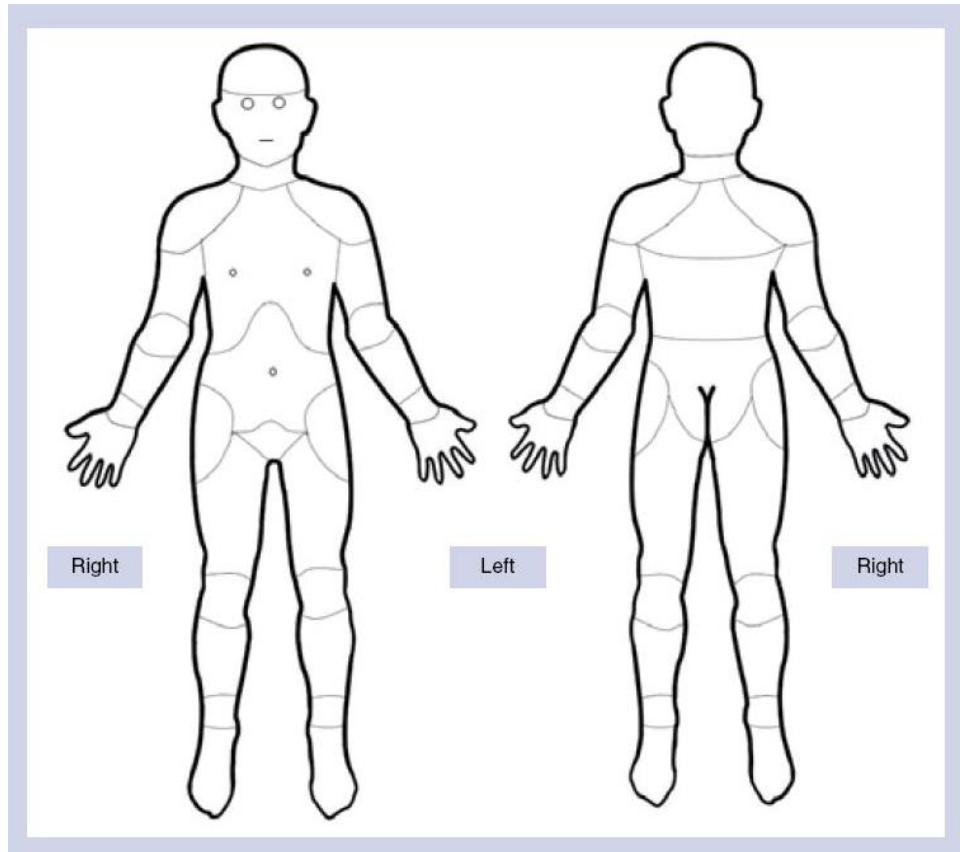
How long does it last? _____ What makes your pain feel better? _____

What makes your pain worse? _____ What treatments are you receiving for your pain? _____

Does pain interfere with your daily activities, sleep, appetite, activity, concentration, emotions, or relationships? Yes No

Please rate your pain by circling the number that best describes your pain at its worst in the past 24 hours: _____ (1=low, 10=high)

On the diagram, circle the areas where you feel pain. If you have a port, tube or catheter place an "X" on its location.





Name: _____ Birthdate: _____

Medical History

- Diabetes
- Hypertension/ High Blood Pressure
- Thyroid Problems
- Heart Disease
- Stroke
- Seizures
- Heart Attack
- Heart Catheterization or Ultrasound
- Artery Catheterization or Ultrasound
- Serious Infection Problems
- Bleeding Disorder/ Clotting
- Stomach or Intestinal Problems
- Kidney Disease
- Tuberculosis
- Asthma
- Pneumonia
- Rheumatic Fever
- Jaundice
- Hepatitis
- STDs
- Other Medical Diagnosis

Have you ever had a mammogram? No Yes, date: _____
 Have you ever had a colonoscopy? No Yes, date: _____
 Do you have a Pacemaker? No Yes, date of most recent check-up: _____

Surgeries

Procedure: _____ Date: _____
 Procedure: _____ Date: _____
 Procedure: _____ Date: _____

Social History

Are you a current smoker? No Yes, how much per day/week? _____ Previous smoker? No Yes, when: _____
 Do you currently drink alcohol? No Yes, how much per day/week? _____
 Do you use illicit/recreational drugs? No Yes, how much per day/week? _____

Family History

Heart Problems/ Murmurs Details: _____
 Allergy Details: _____
 Diabetes Details: _____
 Cancer Type Details: _____
 Bleeding Disorder Details: _____
 Disease Type Details: _____
 Anesthesia Problems Details: _____

Review of Systems

- General:** Chills Fatigue Daytime Sleepiness Weight loss Weight gain
- Allergy:** Environmental Chronic
- Neurological:** Headaches Loss of consciousness Weakness Numbness Tingling
- Eyes:** Vision problems Vision changes
- Respiratory:** Frequent cough Coughing blood Wheezing Shortness of breath Pneumonia Asthma
- Cardiac:** Chest pain Palpitations Edema/swelling
- Gastrointestinal:** Difficulty swallowing Abdominal pain Rectal bleeding Bowel irregularity Bloody stool Constipation Diarrhea
 Nausea Vomiting Heartburn
- Gastro-urinary:** Frequent urination Painful urination Blood in urine Prostate problems
- Hematologic/Lymphatic:** Swollen glands Bleeding problems Night sweats Easy bruising
- Breasts:** Pain in breast Lump Dimpling Nipple discharge
- Endocrine:** Feel warmer than others Feel cooler than others
- Muscular:** Joint aches Muscle aches
- Skin:** Rash Hives Itching Skin or hair changes
- Psychological** Depression Anxiety/Panic



Name: _____ Birthdate: _____

Authorization to Release/Receive information

Your health information is protected by the “Health Insurance Portability and Accountability Act” (HIPAA) and as a result, we cannot discuss any personal information with family or friends unless you give us permission.

Please list the names of persons we are allowed to speak with and what relation they are to you. Please let them know, they must be able to verify your name, social security number, and birthday **before** any information may be released.

- 1. _____ Relation: _____ Phone# _____
- 2. _____ Relation: _____ Phone# _____
- 3. _____ Relation: _____ Phone# _____
- 4. _____ Relation: _____ Phone# _____
- 5. _____ Relation: _____ Phone# _____

If you have any questions, please see the “Notice of Privacy Practices” form or ask the office staff.

Thank you.

Patient’s Signature X _____ Date _____

1876 E. Sabin Drive | Suite 10
Casa Grande, AZ 85122
520.836.9800
520.836.1510 fax

7340 E. Thomas Road
Scottsdale, AZ 85251
480.945.6896
480.945.7287 fax

13184 N. 103rd Drive
Sun City, AZ 85351
623.972.2902
623.972.2539 fax

14506 W. Meeker Boulevard
Sun City West, AZ 85375
623.584.8898
623.584.5511 fax



Name: _____ Birthdate: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

(A copy shall be valid as the original)

Please read the following information as it applies to you. During the course of your care, you will receive a statement from Alliance Cancer Center for the services performed. We will file all insurance claims in our office and the insurance companies will send payments directly to us for our services provided to you. We will also file any secondary insurance if you have other coverage.

Some services may not be covered by your insurance for which you will be responsible; also, services are only covered as long as you are eligible according to your insurance plan.

We will accept the Medicare allowed amount for services, however; Medicare pays 80% of eligible charges, and the patient is responsible for the remaining 20%, unless you have a secondary insurance, which we will be glad to file for you. All other insurance's pay according to the plan you have during your eligible dates, which may leave a balance for which you may be responsible. If you have any questions regarding you plan, please call your insurance company. We want to help you understand our billing procedures and will be happy to assist you in any way we can. If you have any questions regarding your account with us, please call our billing office at 1-877-451-4959.

It is extremely important that you keep us informed of any changes in your insurance coverage as soon as possible.

MEDICARE

I authorize Alliance Cancer Center to release any information needed to the Social Security Administration or its intermediaries or carriers for the purpose of filing claims. I request that my insurance payments be made directly to Cancer Treatment Center at Hazleton for the services provided and I acknowledge that I am financially responsible for any unpaid balance.

MEDICAID

I authorize Alliance Cancer Center to release any information needed to the Medicaid intermediary or carrier for the purpose of filing claims. I request that payment of benefits be made directly to Alliance Cancer Center. I acknowledge that I am financially responsible for any services provided on date for which I am not Medicaid eligible as well as any spend down amounts.

INSURANCE CARRIER

I authorize Alliance Cancer Center to release any information needed to my insurance carrier for the purpose of filing claims. I authorize the insurance payments be made directly to Alliance Cancer Center for the services provided and I acknowledge that I am financially responsible for any unpaid balance.

X

Signature of patient or Authorized Representative

Relation to patient

Physician's Representative

Date Signed

Alliance Cancer Center does not deny benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs.



Name: _____ Birthdate: _____

Release of Records

Patient Name: _____ Date of Birth: _____

Patient Address: _____
Street City State Zip

I hereby authorize: _____
Name of Physician, Facility or person

Located at: _____
Street City State Zip

To release protected health information, contained in the medical record of the above-named patient to the following facility:

1876 E. Sabin Drive Suite 10 Casa Grande, AZ 85122 520.836.9800 520.836.1510 fax	7340 E. Thomas Road Scottsdale, AZ 85251 480.945.6896 480.945.7287 fax	13184 N. 103rd Drive Sun City, AZ 85351 623.972.2902 623.972.2539 fax	14506 W. Meeker Boulevard Sun City West, AZ 85375 623.584.8898 623.584.5511 fax
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<p>Information to be released: Dates of Treatment to be Released: _____ to _____</p> <p> <input checked="" type="checkbox"/> Laboratory Result <input checked="" type="checkbox"/> Imaging (Reports Only) <input checked="" type="checkbox"/> Office Notes <input checked="" type="checkbox"/> Pathology <input checked="" type="checkbox"/> Complete Records <input checked="" type="checkbox"/> Other: _____ </p> <hr/> <p>Purpose of Release: <input checked="" type="checkbox"/> Medical Care <input type="checkbox"/> Other: _____ </p>
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I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not re-disclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.

I understand that I may refuse to sign or revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire 90 days from the date of said authorization unless I provide a written notice of revocation to the releasing facility noted above

X

Signature of Patient or Authorized Representative

Relation to patient



Name: _____ Birthdate: _____

NOTICE OF PRIVACY RIGHTS & PRACTICES ACKNOWLEDGEMENT STATEMENT

We are required by a federal law known as “The Health Insurance Portability and Accountability Act” (HIPAA) as well as by Pennsylvania law to maintain the privacy of your medical and health information, also referred to as “Protected Health Information” (PHI).

Our Notice of Privacy Rights and Practices describes how information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully. When we use or disclose your Protected Health Information, we are required to abide by the terms of the Notice (or any other Notice in effect at the time of the use or disclosure).

You have the right to request in writing that we restrict how Protected Health Information about you is used or disclosed. We are not required to agree to this restriction, but if we do, you will receive written confirmation of our agreement to which we will be bound.

Your Signature below constitutes your acknowledgement that you have received a copy of our Notice of Privacy Rights and Practices, and your consent under Arizona law to the kinds of uses and disclosures of PHI mentioned in our Notice.

Patient’s Signature: _____ Date: _____

Personal Representative: _____ Date: _____

Relationship to patient: _____

Signature of Interpreter: _____ Date: _____

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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.

"Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future health care related services. This Notice of Privacy Practices describes how Alliance may use and disclose your Protected Health Information for treatment, payment, and health care operations. It also discusses other purposes permitted or required by law. Additionally, this Notice describes your rights of access and control of your Protected Health Information.

Alliance HealthCare Services, Inc., its subsidiaries and affiliates, (collectively, "Alliance") is required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to your *Protected Health Information*. We are also required to comply with this Notice of Privacy Practices. We may change its terms in the future and the revised Notice of Privacy Practices will then be effective for all Protected Health Information maintained on or after that date. Our most current Notice of Privacy Practices, as may be revised, is posted on our website – www.alliancehealthcareservices-us.com. You may also obtain a copy of our most current Notice of Privacy Practices at your next appointment or you may ask our Privacy Official to send a printed copy to you.

If you have any questions about this Notice of Privacy Practices, please contact the Alliance Privacy Official at (949) 242-5854 or via email sent to privacy@alliancehealthcareservices-us.com.

1. Uses and Disclosures of Your Protected Health Information

Permitted Routine Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your Protected Health Information will be used and disclosed to support your care and treatment, to ensure that we will receive payment for charges, and to support our administrative operations.

Descriptions and examples of these permitted routine uses and disclosures include:

Treatment: We will use and disclose your Protected Health Information so that we can provide services to you and to allow us to work with others assisting us with your care. For example, we may disclose your Protected Health Information to your physicians to give them information necessary to diagnose and treat your condition. We may also disclose your Protected Health Information to others, such as pharmacy, medical record and radiology entities, as necessary.

Payment: We will use your Protected Health Information so that we can obtain payment for our services. Your insurance carrier may require us to disclose your Protected Health Information before and/or after services are provided to you. This may include determination of eligibility, verification of your insurance benefits, determination of medical necessity, pre-authorization, and insurance billing.

Health Care Operations: We will use your Protected Health Information for the effective and efficient delivery of services to you. This includes quality assessment, employee training, support and maintenance of our equipment and systems, organization accreditation, and coordination with our business partners and suppliers.

Specifically, we may disclose your Protected Health Information to the facility where you are obtaining your services to allow the local storage of scan films and/or patient records. Before your appointment, we may contact you by telephone to confirm its time and location. At the time of your appointment, you may be asked to "sign in" and we may call you by name when it is time for you to be seen. We may also share your Protected Health Information with third party "business associates" that perform certain activities (e.g., billing, transcription services, billing and collections, etc.) on our behalf. In these instances, Alliance will have written agreements in place to protect the privacy of your Protected Health Information.

Possible Uses and Disclosures for Which You Do Not Have an Opportunity to Object

There are also some circumstances that require Alliance to use or disclose your Protected Health Information. We must do so without your authorization and you will not have the opportunity to object.

General situations include:

When Required By Law: We may use or disclose your Protected Health Information to the limited extent required by law. You will be notified, if required by law, of any such uses or disclosures.

To Demonstrate Our Compliance: The U.S. Department of Health and Human Services or other regulatory agency may require us to disclose your Protected Health Information so that we can demonstrate our compliance with laws or if non-compliance is suspected.

Specific situations include:

Abuse or Neglect: Consistent with applicable federal and state laws, we may provide your Protected Health Information to a public health, civil authority, or government agency when child abuse, neglect, or domestic violence may have occurred if: 1) a law requires the disclosure, 2) you agree to the disclosure, 3) a law allows the disclosure and the disclosure is needed to prevent potential serious harm to you or someone else, or 4) a law allows the disclosure, you are unable to agree or disagree, the information is needed for immediate action, and the information will not be used against you.

Criminal Activity: 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.

Law Enforcement: We may disclose Protected Health Information for law enforcement purposes. These purposes include 1) limited information requests for suspect identification and location, 2) identifying victims or researching victims of a crime, 3) suspicion of criminal conduct related to a death, 4) investigation of a crime that occurred on our premises, and 5) when a medical emergency has occurred off of our premises and it is likely that a crime has been committed.

Legal Proceedings: We may disclose Protected Health Information in judicial or administrative proceedings, in response to a court order or administrative hearing (if expressly authorized), and, in certain conditions, in response to a subpoena, discovery request, or other lawful process.

Public Health: We may disclose your Protected Health Information to a public health authority for public health activities such as controlling disease, injury, or disability.

Communicable Diseases: We may disclose your Protected Health Information to a person who may have been exposed to certain communicable diseases or may be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose Protected Health Information to health oversight, regulatory, and accreditation agencies for purposes such as audits, investigations, and inspections.

Food and Drug Administration: We may disclose your Protected Health Information as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products (to enable product recalls, repairs or replacements), or to perform oversight activities.

Inmates: If you are in custody, we may disclose your Protected Health Information to your correctional facility or to law enforcement entities related to your care, to ensure the health and safety of others related to your custody or institution, or to maintain the safety, security, law and order of the facility.

Workers' Compensation: We may disclose your Protected Health Information to comply with workers' compensation laws and other similar programs.

National Security and Military Activities: We may disclose your Protected Health Information to federal officials authorized to conduct national security and intelligence activities. If you are in the Armed Forces, we may disclose your Protected Health Information 1) for activities deemed necessary by command authorities, 2) for benefits eligibility determination by the Department of Veterans Affairs, or 3) to a foreign military authority (if you are a member of their military services).

Possible Uses and Disclosures for Which You May Object

Employment Related Disclosure: We may disclose your Protected Health Information to your employer if: 1) we provide health care services to you at the request of your employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury, 2) your Protected Health Information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance, 3) your employer needs such findings in order to comply with its obligations under applicable law to record such illness or injury or to carry out responsibilities for workplace medical surveillance, and 4) we provide written notice to you at the time the health care services are provided that PHI relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to your employer.

Student Immunization: We may disclose your Protected Health Information to a school about you if you are a student or prospective student of the school, with respect to proof of immunization.

If the use or disclosure of your Protected Health Information is not routinely permitted or legally required, you may have the opportunity to impose limitations on its use and disclosure.

Specifically, you may limit:

Disclosure to Family Members, Relatives or Personal Representatives: Unless you request limitations, we may disclose your Protected Health Information to members of your immediate family, other relatives, or your legally designated health care decision maker. We will limit disclosures to information directly related to their involvement in your health care. You may prevent this disclosure or you may seek to limit it. You may also designate someone other than those listed above (such as a close personal friend) to whom we may disclose your Protected Health Information.

If you are physically unable to express your objection or limitation, we will proceed as noted above if we believe that doing so is in your best interest. If a family member, relative or personal representative is not present, we may use your Protected Health Information to identify a representative. In the case of emergencies and disasters, we may disclose your Protected Health Information to authorized entities assisting in response and relief efforts.

Fundraising

Your Protected Health Information may be used and disclosed for communications to raise funds for Alliance, but you have a right to opt out of receiving such communications. Any such fundraising communication to you will include the opt-out mechanism.

Uses and Disclosures Permitted Only With Your Written Authorization

In situations not covered above, use or disclosure of your Protected Health Information will occur only with your written authorization. These cases include requests you make to Alliance, as well as those we may receive from third parties. For example, you may request that we disclose some or all of your Protected Health Information to an attorney, consultant, or personal acquaintance. Similarly, Alliance may receive a request from a third party to disclose your Protected Health Information. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your Protected Health Information for marketing purposes, and disclosures that constitute a sale of your Protected Health Information, require your written authorization.

Further, certain federal and state laws require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your Protected Health Information that: 1) is maintained in psychotherapy notes; 2) is about mental health and developmental disabilities services; 3) is about alcohol and drug abuse prevention and treatment; 4) is about HIV/AIDS testing, diagnosis, or treatment; 5) is about communicable disease(s); 6) is about genetic testing; or 7) is about sexual assault. In order for us to use or disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

You may later revoke your authorization, in writing, if you change your mind. Should you change your mind, your revocation will only be effective to the extent we have not previously relied on your revocation in making disclosures of your protected health information.

2. Your Rights

These Are Your Privacy Rights and How You Can Exercise Them:

You have the right to obtain a printed copy of this Notice. You may obtain a copy of this Notice at the time of your appointment or you may contact our Privacy Official at any time to request that a copy be sent to you.

You have the right to inspect and copy your Protected Health Information. You may review and receive a copy of your Protected Health Information contained in our Designated Record Set for as long as we maintain the records. A "Designated Record Set" contains medical, billing and any other records that Alliance uses for making clinical and financial decisions about you.

Requests to inspect or obtain your records must be submitted in writing on a record request form to our Privacy Official. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If we maintain your Protected Health Information in one or more Designated Record Sets electronically and if you request an electronic copy of your Protected Health Information, we will provide you with a copy of your Protected Health Information in the electronic form and format that you request, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed upon by you and us. If you provide us with clear, conspicuous and specific directions, we will send a copy of your Protected Health Information (hard copy or electronic) directly to another person of your choosing. We may charge you a reasonable, cost-based fee for any requested copies.

You have the right to request that we amend your Protected Health Information. Should you disagree with any Protected Health Information maintained in our Designated Record Set, you may request, in writing to our Privacy Official, that we change it for as long as we maintain it. Alliance is not required to make the changes you request. If your request is denied, you have the right to file a statement of disagreement with our Privacy Official and we may prepare a rebuttal. You will be provided with a copy of any rebuttal; copies of related correspondence will be included with your Protected Health Information. If you do not submit a statement of disagreement, you may request that we provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment.

You have the right to request how we provide confidential communications to you. You may request special handling for communication of confidential matters. All such requests must be submitted in writing to our Privacy Official. Alliance will accommodate reasonable requests and we will not require you to provide a reason or explanation for your request. We may, as a condition for our agreement, require you to provide additional contact information or other assurances regarding payment of your health care charges.

You have the right to request restrictions relating to your Protected Health Information. You may request restrictions on the use or disclosure of your Protected Health Information. Requests must be in writing and specify 1) the specific restriction requested and 2) to whom you wish it to apply. Before and during your appointment, you may make the request to any Alliance employee you contact. After your appointment, restriction requests must be forwarded to our Privacy Official.

Alliance is not required to agree to all restriction requests. If we agree to the restriction, we will not use or disclose your Protected Health Information in violation of the restriction unless it is necessary to provide emergency treatment to you. The restriction will take effect after it has been approved. A restriction we agree to is not effective to prevent any uses or disclosures specified in the above section, "Possible Uses and Disclosures for Which You Do Not Have an Opportunity to Object."

Upon your written request, and except as otherwise required by law, Alliance will restrict disclosures of Protected Information to a health plan for purposes of carrying out payment or health care operations (but not for purposes of carrying out treatment) so long as the Protected Health Information pertains solely to a health care item or service for which you, or person acting on your behalf (other than the health plan), has paid Alliance out of pocket in full.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information. Your request must be submitted in writing to our Privacy Official. The accounting excludes disclosures for treatment, payment, or health care operations as described in this Notice. It also excludes disclosures we may have made to you, your family members, or designated representatives. Other exceptions, restrictions and limitations may also apply. The accounting will cover a maximum period of six years. You may request a shorter time period for the accounting. After the first request for an accounting within a 12-month period, we may charge you a reasonable, cost-based fee.

You have the right to be notified of a breach of your unsecured Protected Health Information. Alliance will notify you in writing of any such breach (i.e., an unauthorized acquisition, access, use, or disclosure) of your unsecured (i.e., unencrypted) Protected Health Information.

3. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with either Alliance or with the Secretary of the U.S. Department of Health and Human Services. Alliance supports your right to file a complaint and will not take any adverse action against you for doing so.

To file a complaint with Alliance or for additional information about the complaint process, contact the Alliance Privacy Official at (949) 242-5854 or via email sent to privacy@alliancehealthcareservices-us.com.

To file a complaint with the Secretary of the U.S. Department of Health and Human Services, contact:

Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Bldg.
Washington, DC 20201

This Notice is published and effective on August 23, 2013 Attachment A00