

Review of Systems

Indicate by checking “yes” or “no” to any symptoms you have had in **recent** months.

Circle the symptoms you have had if multiple symptoms are listed.

Symptom	No	Yes	How long/where?
Skin rash, sore, or excessive bruising?			
Numbness or tingling?			
Fever, night sweats, or chills?			
Frequent nosebleeds?			
Cough, shortness of breath, wheezing, or asthma?			
Chest pain or pressure?			
Exposed to anyone with tuberculosis?			
“Blacked out”, lost consciousness or had a seizure?			
Abnormal swelling of legs or feet?			
Pain in the calves of your legs when you walk?			
Change in bowel or bladder habits?			
Pain, stiffness, or swelling in your joints or back?			
Do you feel you are at risk for HIV or AIDS?			
Muscle weakness?			
Dizziness or falling?			
Travel outside the US?			

HIPAA and Notice of Privacy Practices

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. **You have the right to request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. **You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively (i.e. electronically), **you may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes.** You then have the right to object or withdraw as provided in this notice. **Complaints:** you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint. This notice was published and became effective on or before **April 14, 2003**. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature _____ Date _____