Mythical Wellness
Holistic Healthcare

Patient Demographic Information

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

If minor, name of responsible party _____

Name you would like to appear on medical records _____

Date of birth ____/____/_____ Social Security # _____-_____-_____ Sex _____ Male ____ Female Home

Address _____ Apt/Suite _____

City _____ State _____ Zip Code _____

Home Phone _____ Other Phone _____ **Best to Use?** Home or Oth

Email address _____

IF LIVING IN NURSING HOME OR ASSISTED LIVING

Name of Facility _____ Room # _____

METHODS OF ALLOWED CONTACT

____ Calls ____ Voicemails _____ Emails _____ Texting (rates may apply)

Do you think of yourself as:

____ Straight or heterosexual _____ Lesbian or gay ____ Bisexual

Occupation _____

Employer _____

Phone # _____

Address _____ City _____ State _____ Zip _____

EDUCATION, LANGUAGE & DEMOGRAPHICS

Highest Level of education _____

Preferred Language _____ Do you need an interpreter? _____

Ethnicity _____ Race _____ **IF**

APPLICABLE, NAME OF SPOUSE/SIGNIFICANT OTHER

Last Name _____ First Name _____ MI _____

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT (If the same as above, leave blank)

Last Name _____ First Name _____ MI _____

Social Security # _____ Relationship to patient _____

Address _____City _____ State _____ Zip _____

Home # _____ Cell # _____

Email address _____

EMERGENCY CONTACT (If diLerent than responsible party/parent/spouse)

Last Name _____ First Name _____ MI _____

Relationship to patient _____

Address _____City _____ State _____ Zip _____

Home # _____ Cell # _____

REFERRAL INFORMATION

Referred by _____

Primary care physician's name _____ Phone #_____

PHARMACY CHOICE

Pharmacy Name _____ City _____

Who can we share your information with? _____

Patient Signature _____ Date _____

Patient representative/parent _____ Date _____

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below.

Reader/Translator _____ Date _____

Mythical Wellness
Holistic Healthcare

Billing Information & Responsible Party/Insurance Information

Last Name _____ First Name _____ MI _____

Insurance Information	
Primary Insurance	Name of Insured
Insurance ID#	
Group ID#	
Secondary Insurance	Name of Insured
Insurance ID# Group #	
Group #	

Patient Signature _____ Date _____

Patient representative/parent _____ Date _____

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Last Name _____ First Name _____ Date of Birth _____

Reason for Visit or Concerns to Address:

_____

_____

Are you under physician's care now? ____ YES ____ NO If yes, please explain: _____

Do you have a special diet? ____ YES ____ NO If yes, please explain: _____

Do you have religious preferences? ____ YES ____ NO If yes, please explain: _____

Any religious restrictions? ____ YES ____ NO If yes, please explain: _____

Do you wish to partake in natural healing options as well as Western Medicine? ____ YES ____ NO

Do you have, or have had, any of the following?

1. Hospitalizations or injury? Y or N
   _____
2. Heart problems, or cardiac stents in the past 6 months? Y or N
3. History of Infective endocarditis? Y or N
4. Artificial heart valve, repaired heart defect? Y or N
5. Pacemaker or Implantable device? Y or N
   Model/Serial # _____
6. Artificial prosthesis (Heart valve or joint)?
   _____ Y or N
7. Rheumatic or scarlet fever? Y or N
8. High or low blood pressure? Y or N
9. A stroke or taking blood thinners? Y or N
10. Anemia or other blood disorder? Y or N
11. Prolonged bleeding (INR >3.5)? Y or N
12. Often exhausted or fatigued? Y or N
13. Emphysema, shortness of breath? Y or N
14. Tuberculosis, chicken pox, measles? Y or N
15. Asthma? Y or N
16. Breathing or sleep problems (apnea)? Y or N
17. Kidney disease? Y or N
18. Liver disease? Y or N
19. Jaundice? Y or N
20. Thyroid, parathyroid disease? Y or N
21. Hormone deficiency? Y or N
22. High cholesterol or taking stains? Y or N
23. Diabetes (HgA1C= _____)? Y or N
24. Stomach or duodenal ulcer? Y or N
25. Digestive disorder (celiac, GERD)? Y or N
26. Constipation? Y or N
27. Diarrhea? Y or N
28. Osteoporosis/osteopenia? Y or N
29. Arthritis, rheumatoid arthritis, lupus? Y or N
30. Glaucoma? Y or N
31. Contact lenses or glasses? Y or N
32. Head or neck injuries? Y or N
33. Concussions or TBI? Y or N
34. Epilepsy, convulsions (seizures)? Y or N
35. Neurological Disorders (ADD,ADHD)? Y or N
36. Frequent Headaches? Y or N
37. Viral infections or cold sores? Y or N
38. Lumps or swelling in the mouth? Y or N
39. Hives, skin rash, hay fever? Y or N
40. Sexually transmitted infections? Y or N
41. HIV/AIDS? Y or N

42. Hepatitis (type _____)? Y or N
43. Tumor, abnormal growth? Y or N
44. Radiation therapy? Y or N
45. Chemotherapy, immunosuppressive? Y or N
46. Emotional problems? Y or N
47. Often unhappy or depressed? Y or N
48. Psychiatric treatment? Y or N
49. Antidepressant medication? Y or N
50. Alcohol or street drug use? Y or N
51. Presently being treated for any other illness?
_____ Y or N
52. Aware of a change in your health in the last 24 hours?
_____ Y or N
53. Taking medication for weight management?
_____ Y or N
54. Taking dietary supplements? Y or N
55. A smoker, smoked previously or smokeless tobacco? Y or N
56. Considered a touchy person? Y or N
57. Impaired sex drive? Y or N
58. MALES- Prostate disorders? Y or N
59. MALES- Impotence concerns? Y or N
60. FEMALES- Pregnant/ or trying? Y or N
61. FEMALES- Currently Breastfeeding? Y or N
62. FEMALES- Taking birth control? Y or N
63. FEMALES- Irregular menstrual cycles? Y or N
64. FEMALES- Painful periods? Y or N

ALLERGIES (include food, medications, and environmental) **____ NO ALLERGIES to FOOD,**

MEDICATIONS OR ENVIRONMENTALS

Allergen	Type of Reaction	Allergen	Type or Reaction

SURGICAL HISTORY (include year)

_____

_____

MEDICATIONS (include supplements and vitamins)

Drug Name	Dose	Purpose

MEDICATIONS CONTINUED...

Drug Name	Dose	Purpose

Patient's Signature _____ Date _____

Patient representative/parent _____ Date _____

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Permission for Telehealth Visits

What is telehealth?
Telemedicine, also referred to as telehealth medicine, is the real-time, audio-visual visit between a provider and patient. It can be used as an alternative to traditional in-person care delivery and, in certain circumstances, can be used to deliver care including the diagnosis, consultation, treatment, education, care management and patient self-management.

How do I use telehealth?
You talk to your provider with a phone, computer or tablet. Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?
You don't have to go to a clinic or hospital to see your provider. It also reduces your risk of getting sick from other people.

What are some of the benefits of telehealth?
No transportation time or costs, reduced wait time, and more detailed and personalized care compared to a telephone call.

What are some of the challenges of telehealth visits?
You and your provider won't be in the same room, so it may feel different from an office visit. Your provider cannot examine you as closely as they might at an in-office visit. Your provider may decide you still need an office visit. Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?
We will not record visits with your provider. If people are close to you, they may hear something you do not want them to know. You should be in a private place so other people cannot hear you. Your provider will tell you if someone else from their office can hear or see you. We use HIPAA-compliant, encrypted telehealth technology that is designed to protect your privacy. If you use the internet for telehealth, use a network that is private and secure. There is a very small chance that someone could use technology to hear or see your telehealth visit.

What types of visits can telehealth be used for?
Telehealth is best suited for interactions with established patients who do not require a physical exam or lab work.

What types of visits are not appropriate for telehealth?
Telehealth is not suited for a physical examination or lab testing and cannot be used for new-patient evaluations.

What if I want an office visit, not a telehealth visit?
That decision is up to you and your provider. Find out what options are available to you by calling the practice.

What if I try telehealth and don't like it?
You can stop using telehealth any time, even during a telehealth visit. You can still get an office visit if you no longer want a telehealth visit. If you decide you do not want to use telehealth again, call **928.362.0577** and say you want to stop.

How much does a telehealth visit cost?
What you pay depends on your insurance. If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?
No. Only sign this document if you want to use telehealth.

What does it mean if I sign this document?
If you sign this document, you agree that: We talked about the information in this document. We answered all your questions. You want a telehealth visit.

If you sign this document, we will give you a copy.

Your name (please print) **Date** _____

Your signature _____ **Date** _____

Practice Financial Policy

Thank you for choosing **Mythical Wellness, PLLC,** as your health care provider. We are committed to building a successful physician patient relationship, and the success of your medical treatment and care. Your understanding of our Practice Financial Policy and payment for services are important parts of this relationship. For your convenience, this document discusses a few commonly asked financial policy questions. If you need further information or assistance about any of these policies, please ask to speak with our Practice Manager.

When are payments due?
All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made.

How may I pay?
We accept payment by cash, check, VISA, and MasterCard. We will only accept post-dated checks when they are provided within an approved payment plan.

Will you bill my insurance?
Insurance is a contract between you and your insurance company. In most cases, we are not a party to this contract. We will bill your primary insurance company on your behalf as a courtesy to you. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information.

It is your responsibility to notify our office promptly of any patient information changes (ie, address, name, insurance information) to facilitate appropriate billing for the services rendered to you. Failure to provide complete and accurate insurance information may result in the entire bill being categorized as a patient's responsibility.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Which plans do you contract with?
Mythical Wellness, PLLC accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is a good idea for you to contact your insurance company prior to your appointment and verify if we are a participating provider as per your plan.

What if my plan does not contract with you?
If we are not a provider under your insurance plan, you will be responsible for payment in full at the time of service. As a courtesy, however, we will file your initial insurance claim, and if not paid within 45 days, you will be responsible for the total bill. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you.

What is my financial responsibility for services?
It is your responsibility to verify that the physicians and the practice where you are seeking treatment are listed as authorized providers under your insurance plan. Your employer or insurance company should be able to provide a current provider listing.

If you have:
<u>Workers' Compensation</u>

- *If we have verified the claim with your carrier*: No payment is necessary at the time of the visit.
- *If we are not able to verify your claim*: Your appointment will need to be rescheduled.

Our staff will schedule your appointment after your worker's compensation carrier calls in advance to verify the accident date, claim number, primary care physician, employer information, and referral procedures.

<u>Workers' Compensation (Out of State) and Occupational Injury</u>

- Payment in full is requested at the time of the visit.

Our staff will provide a receipt to file the claim with your carrier.

The patient or the patient's legal representative is ultimately responsible for all charges for services rendered. "Non-covered" means that a service will not be paid for under your insurance plan. If non-covered services are provided, you will be expected to pay for these services at the time they are provided or when you receive a statement or explanation of benefits (EOB) from your insurance provider denying payment.

Your insurance company offers appeal procedures. We will not under any circumstances falsify or change a diagnosis or symptom to convince an insurer to pay for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered. We cannot offer services without expectation of payment, and if you receive non-covered services, you must agree to pay for these services if your insurance company does not. If you are unsure whether a service is covered by your plan, ultimately, it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies, and your potential financial responsibility.

What if I don't have insurance?
Self-pay accounts are used for patients without insurance coverage, patients covered by insurance plans which the office does not accept, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating in their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full for services rendered to them and will be asked to make payment arrangements prior to services being rendered. Emergency services provided to self-pay patients will be billed to the patient.

At the sole discretion of the practice, extended payment arrangements may be made for patients. Please speak with our practice manager to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and reasonable costs.

I received a bill even though I have secondary insurance.
Having secondary insurance does not necessarily mean that your services are 100% covered. Secondary insurance policies typically pay according to a coordination of benefits with the primary insurance.

What if I have billing or insurance questions?
Mythical Wellness, PLLC is supported by a sta\ of dedicated professionals. Our sta\ can assist with most financial questions and help relieve the patient/caregiver of burdensome paperwork. Please ask if you have any questions about our fees, our policies, or your responsibilities.
Do you bill workers' compensation?
We will bill workers' compensation for verified claims. It is the patient's responsibility to provide our o\ice sta\ with employer authorization and contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility.
At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

I received more than one bill for my procedure/service.
Please note that **Mythical Wellness, PLLC** only bills for services rendered by our clinical team during the procedure. If you believe you have been accidentally billed twice for the same service, please get in touch with our o\ice for clarification or resolution.

Do you bill other third parties?
We do not bill third parties for services rendered to you. Our relationship is with you and not with the third-party liability insurer or policy carrier (eg, auto or homeowner). It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You will be asked to pay in full for the services we provide you. All formalities required by your insurer and the third party should be promptly completed by you. If we receive a denial of your claim, you will be responsible for payment in full.

What if my insurance pays late?
As a courtesy to you, we bill your insurance company for services on your behalf. If any insurance company fails to process payment for services within 45 days from the date of the claim submission, the total balance will be determined to be the patient's responsibility.

Will I receive statements or bills?
It is our office policy that all accounts with pending balances be sent two statements, each one month apart. If payment is not made on the account, a single phone call will be made to try and make payment arrangements. Accounts with unpaid balances for 90 calendar days or more will be sent to an external collection agency or attorney for collection. Unpaid bills can also lead to possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for the collection's costs, including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our o\ice if you are 18 years old or older and receiving treatment, you are ultimately responsible for payment of the service. Our o\ice will not bill any other personal party.

Do you refer unpaid bills to collection agencies?
If a patient cannot pay the balance on their account according to the financial policy will be referred to an outside collection agency or an attorney for further action.

What if my child needs to see a physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Do you charge a penalty for returned payments?
Any charges incurred by the practice collecting balances owed to us during the collection process may be charged to the patient. Returned checks, credit card chargebacks, or returned payments will attract a minimum $35 penalty in addition to the balance owed. Accounts with returned payments will be expected to make payments via cash, money order, or cashier's checks only.

Can you waive my copay?
We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.

I have a hardship. How can you help me?
Some patients may accrue large balances for services provided. At the sole discretion of the practice leadership, we will work with you to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid, we will need proof of financial hardship. We may be forced to pursue collections of balances in the absence of tangible proof of hardship.

Do you charge for completing forms?
Completing disability forms, FMLA forms, and other requested supplemental insurance forms require additional time by our provider. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 5 business days for this process.

Expedited requests will be charged a special handling fee of $25.00.

What if I missed my appointment to see the physician?

We understand that on rare occasions, issues may arise, causing you to miss your appointment when you cannot notify our office before your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office at least 24 hours prior to having it rescheduled.

Our highly skilled physicians are committed to your well-being and have reserved time just for you. Patients who miss more than one appointment without notifying our office 24 hours before the appointment time are subject to a $20 missed appointment fee billed to the patient.

I have read, understand, and agree to the above Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by Mythical Wellness, PLLC., to simplify insurance reimbursement for the services provided to me. I acknowledge that these policies do not obligate Mythical Wellness, PLLC., to extend credit to me for services provided.

Patient or authorized representative signature: _____ Date: _____

Patient or authorized representative name: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION PURSUANT TO FEDERAL REGULATIONS. PLEASE REVIEW IT CAREFULLY.

At **Mythical Wellness, PLLC** ("Practice"), we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive directly from one of our physicians. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices ("Notice") applies to all the records of your care generated by Practice.

This Notice will tell you about the ways in which Practice may use and disclose your protected health information ("PHI"). This Notice also describes your rights and certain obligations Practice has regarding the use and disclosure of PHI.

REGULATORY REQUIREMENTS.
Practice is required by law to maintain the privacy of your PHI, to provide individuals with notice of Practice's legal duties and privacy practices with respect to PHI, and to abide by the terms described in the Notice currently in effect.

RIGHTS.
You have the following rights regarding your PHI:

Restrictions.
You may request that Practice restrict the use and disclosure of your PHI. To request restrictions, you must make your request in writing to our Privacy Officer using the applicable Practice form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

Alternative Communications.
You have the right to request that communications of PHI to you from the practice be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing using Practice's form and sent to the Privacy Officer. Practice will accommodate your reasonable requests.

Inspect and Copy.
Generally, you have the right to inspect and copy your PHI that Practice maintains, provided you make your request in writing to Practice's Privacy Officer. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If Practice does not maintain the PHI you request and if we know where that PHI is located, we will tell you how to redirect your request.

Amendment.
If you believe that your PHI maintained by Practice is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing, and it must explain why you are requesting an amendment to your PHI. We can deny your request if your request relates to PHI: (i) not created by Practice; (ii) not part of the records Practice maintains; (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and Practice's denial attached; and (iii) complain about the denial.

Accounting of Disclosures.
You generally have the right to request and receive a list of the disclosures of your PHI we have made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosures made at your request, with your authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment and health care operations; (ii) made to you; (iii) for Practice's patient list; (iv) for national security or intelligence purposes; or (v) to law enforcement officials. You should submit any such request to Practice's Privacy Officer. Practice will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of the costs of providing the list.

Right to Copy of Notice.
You have the right to receive a paper copy of this notice upon request. To obtain a paper copy of this notice, please contact the Privacy Officer at the address and contact information stated at the end of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
Practice may use or disclose your PHI for the purposes described below **without obtaining written authorization from you**. In

addition, Practice and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

For Treatment.
Practice may use and disclose PHI while providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider.

For Payment.
Practice may use and disclose PHI to bill and collect payment for the health care services provided to you. For example, Practice may need to give PHI to your health plan to be reimbursed for the services provided to you. Practice may also disclose PHI to its business associates, such as billing companies, claims processing companies and others that assist in processing health claims. Practice may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations.
Practice may use and disclose PHI as part of its operations, including for quality assessment and improvements, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, credentialing and peer review activities, and health care fraud and abuse detection or compliance, and management and administration. Practice may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants and others for review and learning purposes, to help make sure Practice is complying with all applicable laws, and to help Practice continue to provide quality health care to its patients.

As Required by Law and Law Enforcement.
Practice may use or disclose PHI when required to do so by applicable laws and when ordered to do so in a judicial or administrative proceeding. Practice may also use or disclose PHI upon a properly documented and limited request from law enforcement agencies.

For Public Health Activities and Public Health Risks.
Practice may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, or notifying a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities.
Practice may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs and compliance with civil rights laws.

Coroners, Medical Examiners and Funeral Directors.
Practice may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Research.
Under certain circumstances, Practice may use and disclose PHI for medical research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication with those who received another, for the same condition.

To Avoid a Serious Threat to Health or Safety.
Practice may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions.
Practice may use and disclose PHI of military personnel and veterans under certain circumstances. Practice may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the president or other authorized persons or foreign heads of state or to conduct special investigations.

Disclosures to You or for HIPAA Compliance Investigations.
Practice may disclose your PHI to you or to your personal representative and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. Practice must disclose your PHI to the secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate Practice’s compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996.

Patient List; Marketing.
Unless you object, Practice may use some of your PHI to maintain a list of patients it has served. This information may include your name, treatment facility, and the services Practice provided to you. This patient list and the information on it may be used for marketing purposes.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care.
Unless you object, Practice may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care.

OTHER USES AND DISCLOSURES.
Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations; you have the right to revoke your authorization in writing. If you revoke your authorization, Practice will no longer use or disclose PHI about you for the reasons covered in your written authorization. Please understand that Practice is unable to recover any disclosures already made with your authorization, and that Practice is required to retain records of the care provided to you.

RIGHT TO FILE A COMPLAINT.
At Practice, we value the relationships we develop with our patients, our patients' privacy, and the trust our patients' have in us. As such, we make every effort to remedy any issues or concerns you may have. You may submit any complaint regarding your privacy rights to:

Mythical Wellness, PLLC
Victoria Angel
management@mythicalwellness.com

You also have the right to file a complaint with the secretary of the Department of Health and Human Services, Office for Civil Rights. You will not be penalized for filing a complaint. You may contact the Office for Civil Rights at:

Office for Civil Rights
U.S. Department of Health and Human Services (Arizona)
2005 N Central Avenue
Phoenix, AZ 85004

Ph: 602.542.5025

PLEASE CONTACT THE PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OF PRIVACY PRACTICES OR YOUR PRIVACY RIGHTS.

Mythical Wellness
Holistic Healthcare

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand the *Notice of Privacy Practices* document containing a more complete description of the use and disclosures of my health information. I understand that Mythical Wellness, PLLC ("Practice") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Do we have you permission to:

Leave a message on your answering machine?	____ YES	____ NO
Send a text message with appointment or medication reminders?	____ YES	____ NO
Send an email message with appointment or medication reminder?	____ YES	____ NO
Confirm appointments by leaving messages or speaking with family?	____ YES	____ NO
Leave pre-medication reminders (if applicable)?	____ YES	____ NO
Speak to household members concerning your care?	____ YES	____ NO

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Name/Relationship to Patient	Signature	Date

For Office Use Only

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgement of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

___ Patient or guardian refused to sign ___ Emergency situation

___ Other: _____