119 West H Ave., North Little Rock, Arkansas 72116
Phone 501-772-3224 · Fax 501-771-7648

Patient Information Sheet

Last Name: ______________________ First Name: _____________________ Middle: __________

DOB: _____/______/______ SS #_____________________ Marital Status: **S M W D** or **Other**

Gender: **M F** Home #_________________Work #________________ Cell #_________________

Home Address: ________________________ City: _______________ ST: ______ Zip: _________

Employer Name: _____________________________ Occupation: ___________________________

Spouse/Guardian

Last Name: ___________________ First Name: _______________________ Middle: ___________

Cell # ______________________ Relationship: ___________________ DOB: ____/_____/______

EMERGENCY Contact: Name and Address of nearest relative or friend not living with you

Last Name: ____________________ First Name: ____________________ Relation: ____________

Home # ___________________ Work # _______________________ Cell # ___________________

Insurance Information: PRIMARY

Insurance: __________________________ ID # ___________________________________
Insurance: SECONDRY

Insurance: ___________________________ID # ___________________________________

Responsible Party: Complete this section if you are not the patient but are the responsible for payment:

Responsible Party Name: _____________________________________ Relation: _______________

Home Address: _______________________ City: _____________ ST: _____ Zip: ______________

Home # ______________________ Cell # ______________________ Work # _________________

If my insurance company refuses payment for therapy service rendered by AR Lymphedema & Therapy Providers, I understand that I am responsible for the full amount of each claim.

____ ______________________

Patient/Parent/Responsible Party signature Date:

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Rates for Physical and Occupational Therapy

Insurance	Private	Insurance Deductible Not Met*
$250	$200	$69

Therapy treatment is billed in units and is billed at the following rates:

Treatment	Insurance Rate	Private Rate	Insurance Deductible Not Met
60 minutes/4 units	$160	$91.00	$84
45 minutes/3 units	$120	$68.25	$63
30 minutes/2 units	$80	$45.50	$42
15 minutes/1 unit	$40	$22.75	$21

Insurance Deductibles*

If your insurance deductible has not been met for the year, you may choose how we process the charges from your visit. You will need to make a decision prior to treatment and continue with that option to the completion of treatment.

Option 1 - You may choose to pay privately and not process through insurance. In this case you will pay at each visit according to the Private Rate shown above. This transaction will not process through insurance and you will not receive credit toward your deductible.

Option 2 - You may pay a reduced rate as shown in the chart above at each visit and be billed for the difference between what your insurance allows and what you paid. This transaction will process through your insurance and you will receive credit toward your deductible.

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If my insurance company refuses payment for therapy services rendered by Arkansas Lymphedema and Physical Therapy Providers, I understand that I am responsible for the full amount of each claim at the "Private Pay Rate."

________________________________ **Patient Signature**

________________________ **Date**

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Arkansas 72116
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Arkansas Lymphedema & Therapy Providers

Are you currently or have you received skilled assistance in your home within the last six months? (ie: nurse, home assistance, in-home therapy, etc.) Yes No

If yes, please list type of service & agency provided by: ___________________________

____

It is your responsibility to inform our office if you are receiving Home Health services so that we can make the appropriate financial arrangements for your treatment. Failure to do so could result in you being responsible for all treatment costs. As a Medicare beneficiary, you are subject to possible payment liability if you obtain services from anyone other than your primary HHA.

_____________ (initial)

Are you currently receiving any other therapy services? Yes No

Most private insurance carriers will only pay for one physical therapy provider per day. If you are in treatment with other physical therapy providers, it is your responsibility to schedule on non-concurrent days. _____________(initial)

Have you received any other therapy services in the current calendar year? Yes No

Is injury result of a work-related accident or automobile accident? Yes No

Financial Policy:

Thank you for choosing us as your physical therapy provider. We are committed to your treatment being successful. Please understand that payment on your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Insurance Patients: Your health insurance is a contract between you and your insurance company; we are not a party to this contract. Patients are responsible for understanding their health insurance coverage and benefits. If you have provided all necessary insurance information to our office, then we will bill your insurance company as a courtesy. However, you are financially responsible for any charges not covered by your insurance plan. Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation than what we collected in the office, you will receive a statement from our billing company. We require your co-payment to be paid at the time of service. We accept cash, debit/credit cards, and personal checks.

Self-Pay Patients: You are required to sign a self-pay agreement letter. **You are responsible for payment of services at each visit.** Please speak with the office manager for available payment options.

I have read the Financial Policy. I understand and agree to the Financial Policy

____ _________________________

Signature of Patient or Responsible Party **Date**

119 West H Ave., North Little Rock, Arkansas 72116
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"The ONLY Independent Arkansas Therapy Clinic Offering Services by a Certified Lymphedema Specialist."

Consent for Release of Information

Client's Name:____________________________________Date of Birth:____________

I hereby give authorization to Arkansas Lymphedema & Therapy Providers to release information and receive information regarding needs and services from the following:

Physician: ____

Primary Care Physician: _______________________________________

Hospital: ____

Therapist: ____

School: ____

Other: ____

____

Medical information to another Physician or Insurance Company to assist in treatment or claim processing.

_________________________________ ___________
Signature of Patient/Parent/Guardian Date

Assignment of Benefits
I authorize payment of medical benefits be paid directly for services rendered.

Authorization for Treatment
I authorize treatment be given as ordered by my physician.

_________________________________ ___________
Signature of Patient/Parent/Guardian Date

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Consent/Authorization to Bill Insurance

I hereby give consent to the physical/occupational therapists at Arkansas Lymphedema & Therapy Providers (hereafter to be referred to as ALTP) to provide therapy services to myself for conditions warranted by physical/occupational therapy treatment.

If my account with ALTP is to be paid by health insurance, workman's compensation, or automobile insurance, I hereby request and authorize my insurance company, or other appropriate party, to pay directly to ALTP any proceeds payable under my policy(s) for the professional and/or medical services rendered. All allowable benefits will be paid to ALTP under my current insurance policy(s) as payment toward the total charges assessed to me for ALTP's professional services.

I agree to pay to ALTP any allowable balance (for example, copays, deductibles, coinsurance) accrued for professional services over and above the insurance payment.

I agree that it is my responsibility to know and understand my insurance policy regarding referrals, precertification, copayments, deductibles, and coinsurance.

ALTP agrees to assist the patient in obtaining maximum benefits from his/her insurance company. However, ALTP is not obligated to withhold statements or to wait for insurance payment on a patient account before receiving payment for our services.

ALTP reserves the right to utilize a collection agency in collecting on delinquent accounts. If a collection service is utilized, I understand that I am responsible for any and all costs incurrent in the collecting of my balance. This includes, but may not be limited to, attorney fees and a collection fee of 30%. Any check that is returned for insufficient funds will result in a charge of $25.00 for each occurrence.

I have been provided with an opportunity to review this documentation, and this is shown through my signing of this consent/authorization.

Signature of Patient or Responsible Party ____

Today's Date __________________________

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Patient Attendance Policy

At Arkansas Lymphedema and Therapy Providers we strive to give every client an exceptional and individualized experience. Our clients are seen one-on-one by a Lymphedema therapist. We make every effort to stay on time and see you at your appointed times. We also make every effort, as cancellations arise, to schedule clients who may be having serious complications due to their edema. In order for us to provide optimal care to those who are currently being treated and those who are awaiting treatment, we ask three things of you:

1) Please arrive 10-15 minutes prior to your scheduled appointment. This will allow for the preparation time needed prior to your treatment. If work or other scheduling conflicts make this difficult, please notify your therapist.

2) If you become aware of your inability to attend a scheduled appointment, a 24 hour notice is requested. If we can reschedule you for another time that day, we will do so. If not, you will be rescheduled at the earliest appointment time possible. It may also be possible to have a shortened treatment time, addressing any critical needs.
   A $40.00 fee will be charged for No Call/ No Show appointment.

3) If you become ill the day of your scheduled appointment, please call to cancel before your appointment time. **If you do not call and do not show for an accumulative of three scheduled appointment, action will have to be taken.**
   a. **Verbal counsel with your therapist will be performed discussing the need for compliance.**
   b. **If a fourth No Call/No Show occurs you will be removed from the schedule, your physician will be contacted, and a new referral will be required to return for continued therapy**.

We understand that no one can predict what is dealt to us from day to day, but we ask that you help us to make this experience a positive one for you, other patients, and our staff. We are very excited to have you here and look forward to helping you in every way possible.

Patient Signature: ______________________________ Date: _________________________

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INFORMED CONSENT

I HEREBY GIVE MY CONSENT TO BE PHOTOGRAPHED.

We would like your authorization to take before and after photos to document your therapy progress. Photos become a part of your permanent medical record and will only be used as you authorize below. Identifiable characteristics such as your name or face will not be included in the photographs.

€ Photographs may be used by the therapist, physician and payer source to present a condition or demonstrate progress.

€ Photographs may be used to the Arkansas Lymphedema Graduation Board to indicate therapy completion and show progress.

€ Photographs may be used by Arkansas Lymphedema for online or printed marketing.

______________________________ ______________________________

Signature **Date**

Record of Photographs Taken-Therapist use only

Date of Evalutaion Photo: ______________

Date of Subsequent Photo: ______________

Date of Subsequent Photo: ______________

Date of Discharge Photo: _______________

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INTAKE QUESTIONNAIRE

Please circle all of the following diagnoses that apply to you: (please add any not listed)

Asthma	Diabetes	Kidney Disease/Renal Failure
Aortic/Abdominal Aneurysm	Arterial Disease	Cellulitis or Infections
COPD	Heart Attack	Arthritis
Congestive Heart Failure/CHF	High Blood Pressure/HTN	Rheumatoid Arthritis
Hernia	Spinal Cord Injury	Liver Disease
Diverticulitis	Colitis	Stroke/TIA
Cancer: ____________________	Osteoporosis	Orthopedic problems_______________
Other: ______________________	Bipolar disorder	Depression

Please list surgeries and dates (month & year if possible): (if you need more room, please use back of this page)
Circle any that apply:

Mastectomy	_________________________	_________________________
Reconstruction	_________________________	_________________________
Lumpectomy	_________________________	_________________________
______________________________	_________________________	_________________________

Please list any known drug allergies: __No known allergies __LATEX allergy
Allergies: ____

Please supply a list of medications you currently take; please include supplements, herbs, vitamins, etc.
(we will make a copy of your printed list, if you have one; use back of page if needed).________________________
____
____
Please list any CHEMOTHERAPY you are currently on: ____
____
Have you been hospitalized recently? YES NO
If YES: Where(which hospital):___________________________________ Date(s):_________________________
Reason:__________________________
Other info:____

Have you ever had CELLULITIS or an INFECTION in the limb that is swollen? YES NO
If yes, When/How long ago? ____
If yes, Were you hospitalized? YES NO If yes, Where & for How long:__________________________

Have you had wounds/ulcers/sores on the swollen limb? YES NO
Do you have ANY wounds now? YES NO If yes, where?____

Have you been or are you being treated at a wound care facility or Clinic? YES NO
If yes, where?____________________________

Have you had “leaking” or “weeping” from the swollen limb? YES NO

Are you having leaking or weeping now? YES NO If yes, for how long_____________________________

Are you currently taking a “water pill” or Diuretic for the swelling? YES NO

If yes, has the dosage been changed or increased recently? YES NO

Please circle any treatments you have received for your swelling, or have been directed to do for your swelling:

Elevation of swollen limb Exercise Surgery

Compression stockings/Sleeve Compression pump Antibiotics

Manual Lymphatic Drainage Compression bandaging PROFORE

Traditional massage Diuretics (“water pills”) Unaboot

Are you currently taking any of the following CHEMOTHERAPY medications: (please circle any that apply)

ZELODA DOXIL DOXYROBICIN ADRIAMYOSIN(“RED DEVIL”)

Did you take any of these in the past? If yes, please indicate that with a “P”

Functional Ability: (please check all that apply)

__I live alone

__I live with a spouse/significant other

__I live in an Assisted Living or Independent Living Center

__I require assistance with bathing/dressing:

who helps you with these things:________________

__ I am fully independent in my daily activities.

__I am the caregiver for a spouse/family member

__I live in a Nursing Home

Do you use any tobacco products? (circle any that apply) cigarettes chewing tobacco/dip e-cigarettes

How many/how often do you use these tobacco products? ____packs per day Other: ____________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you’re a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Continued on next page.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not Answer
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides, or medical care, or from being with people you wanted to be with?	YES	NO	Did not Answer
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not Answer
4. Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not Answer
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not Answer

Please add any other comments about your answers that you feel we need to know:
____
____

What is your goal for attending therapy (what do you want to accomplish)?_________________________________
____

How did you hear about us? (check all that apply)
___ Doctor's office: _________________________________
___ Physical or Occupational Therapist: ________________
___ Friend/relative who received treatment here.
___ OTHER: ____

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SUMMARY OF NOTICE OF PRIVACY PRACTICES
This summary is provided to assist you in understanding the attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

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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 April 14, 2003, 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

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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. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

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. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

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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 a 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 $___ for each page, $___ per hour for staff time to locate and copy your protected health information, and

postage if you want the copies mailed to you. 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 our business associates or we disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). 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.

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:
TROY or STACY ALBERSON
Telephone: 501-772-3224; Fax: 501-771-7648
admin@arlymphadema.com
119 West H Ave ·North Little Rock, Arkansas 72116

119 West H Ave., North Little Rock, Arkansas 72116
Phone 501-772-3224 · Fax 501-771-7648

ACKNOWLEDGMENT 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.

____________________________________ __________________________________
Signature Date

____
Patient Name (please print)