Jaffe Ethical Addiction & Pain Care LLC

2051 Evergreen Lane Suite C Show Low, Arizona, 85901

Phone: 928-892-5776

Fax: 928-495-5514

New Patient Demographics

Purpose of this form: To have your information on file to: identify you in our office, to have an emergency contact on record, to contact your doctors and insurance companies for information used in your treatment and billing, and to identify your preferred pharmacy. Please complete in advance of your appointment and email to: info@jaffepaincare.com or fax to the number above

Email Address: _____

First Name: _____MI: _____ Last Name: _____

DOB: ___/___/_____ Age: _____ Sex: M F Social Security Number:_____

Mobile Phone: _____ Home Phone: _____Work Phone: _____

Preferred Spoken Language: _____ Translator needed? Yes No

Mailing Address: _____

City:_____ State: _____ Zip Code: _____

Physical Address: _____

City:_____ State: _____ Zip Code: _____

If you have a resuscitation designation, please provide us with the documentation. Otherwise, all patients in our care are considered for resuscitation in an emergency.

The U.S. government requires we ask the following two questions:

Race: [ ] White [ ] American Indian/Alaskan Native [ ] Native Hawaiian/Pacific Islander

[ ] Black/African American [ ] Decline to specify [ ] Other

Ethnicity/Culture/Heritage: _____ [ ] Hispanic/Latino [ ] Decline to Specify

Emergency Contact Information Name of Person:_____

Relationship to Patient: _____

Phone Number: _____

TURN TO OTHER SIDE

Employment Status (if retired, previous type of employment) _____

Employer Name: _____

Is this problem related to an accident? Yes No Work Related? Yes No

Lawsuit ongoing? Yes No Attorney's Name: _____
Phone Number: _____

Referring Provider Information Name of provider: _____

Primary Care Provider Information Name of provider: _____

Current Pain Management Provider Name: _____

Additional Provider for care: Provider Name: _____

Preferred Pharmacy Name: _____ Phone Number _____

Location: _____

Relationship Status: (Circle correct answer)

Single Married Divorced Widow(er) Separated Partnered

Sexual Preference: Heterosexual Homosexual/Lesbian Other Prefer Not to say

Number of Children _____

INSURANCE

Primary Insurance: _____ ID #_____ Group #_____

Address_____

Subscriber: _____ DOB___/___/_____ SSN_____

Specialist Co-Pay Amount $_____

Secondary Insurance: _____ ID #_____ Group #_____

Other Insurance: _____ ID #_____ Group #_____

Please provide government issued photo ID/DL and insurance cards to the front desk to scan

Guarantor _____

Patient/Guardian Signature: _____ Date: _____

Jaffe Ethical Addiction & Pain Care LLC

NEW PATIENT MEDICAL INTAKE FORMS

Purpose of these forms: To gather personal and medical information that will help us understand and plan for your visit.

Date: _____

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

What is the main reason for your visit today? _____

Right	Left	Middle			Describe your pain	
❑ Back Pain	[ ]	[ ]	[ ]	[ ] Shooting	[ ] Tingling
❑ Neck Pain	[ ]	[ ]	[ ]	[ ] Hot/Burning pain	[ ] Sharp pain
❑ Leg Pain	[ ]	[ ]	[ ]	[ ] Numbness/Weakness	[ ] Stabbing pain
❑ Arm Pain	[ ]	[ ]	[ ]	[ ] Cramping/throbing	[ ] Dull/Aching
❑ Stroke				[ ] Radiating pain	[ ] Other
❑ Other _____					

History of Present Illness

Please Answer the following questions:

When did the problem start? _____

_____

How did the problem start? _____

_____

Has the problem recently gotten worse? _____

Did this injury occur as the result of an accident or while at work? _____

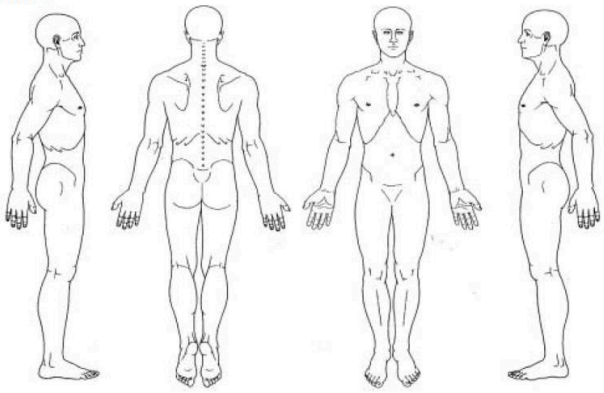
What treatments have you had for this problem? (please explain)

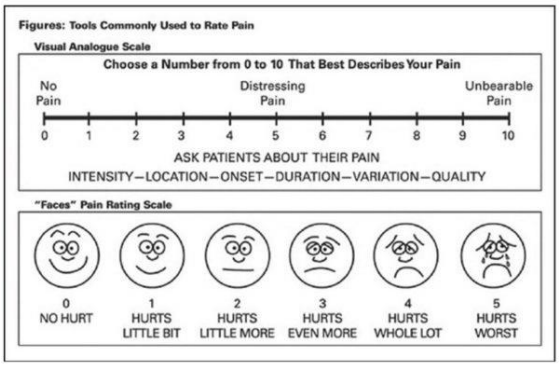
- ❑ Physical therapy _____
- ❑ Chiropractic _____
- ❑ Medications that have helped _____
- ❑ Medications that have NOT helped _____ _____
- ❑ Injection(s) _____
- ❑ Surgery _____
- ❑ OTHER _____

Does anything help or make the problem worse?

- ❑ Sitting/Standing
- ❑ Bending/Lifting
- ❑ Walking
- ❑ Sleeping/Lying down
- ❑ Sneezing/coughing
- ❑ Exercising
- ❑ Other _____

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.





How long does the problem last?

[ ] Minutes [ ] Hours [ ] Intermittent

Associated symptoms:

- ❑ Weakness

[ ] Constant [ ] Other _____

- ❑ Poor Sleep
- ❑ Mood changes
- ❑ Bladder/bowel incontinence

Drug Allergies: _____
_____
_____
_____

Reactions: _____
_____
_____

- ❑ **No Known Drug Allergies**

Current Medications:

Medication	Strength	Directions	Prescriber

****IF medications exceed provided space, please attach a current medication list****

Previous Surgeries	Date	Location

****** Have you or any of your blood relatives had any reactions with surgery or the use of anesthesia? Yes or No ******

Have you had any X-Rays, CTs and/or MRIs done? [ ] Yes [ ] No

If yes, where at, and when? (we may request records): Location: _____ Date: _____

Location: _____ Date: _____

Social/Family History:

Marital Status: M S D W Separated
Tobacco Use: Smoker Ex-Smoker Vape
Alcohol Use: Frequently Occasionally Former Drinker Never
Exercise: [ ] Yes [ ] No # x weekly: ____

Retired or Employed?_____
Occupation: _____
Medical Marijuana Card: [ ] Yes [ ] No
History of drug abuse: [ ]Yes [ ] No

Number of Children: _____
Mother: Living/Deceased Cause: _____
Father: Living/Deceased Cause:_____

Review of Systems (ROS): Please check the box if you are currently having any of the following:

- ❑ Fever, weight loss, sweats
- ❑ Cough, Sputum productions, wheezing
- ❑ Weakness or paralysis of arms or legs
- ❑ Headache: How Often? _____
- ❑ Dizziness, vision change, lightheadedness
- ❑ Swelling or rash: _____
- ❑ Abdominal pain
- ❑ Change in bowel habits, nausea
- ❑ Chest pain, palpitations
- ❑ Pregnant or possibly pregnant? _____

Review of Systems (ROS) Continued: Have you ever had or been told you have the following? (please check all that apply)

Cardiovascular:
- ❑ Chest pain, discomfort or angina

Respiratory:
- ❑ Asthma

Liver/Kidney/Blood:
- ❑ Kidney disease

- ❑ Heart disease
- ❑ MI, heart attack, blocked artery
- ❑ Congestive heart failure
- ❑ High blood pressure
- ❑ Peripheral vascular disease
- ❑ Abnormal heartbeat, arrhythmia
- ❑ Pacemaker
- ❑ Angioplasty or heart catheter
- ❑ Rheumatic fever
- ❑ Damaged Heart Valve
- ❑ Swelling
- ❑ Clotting complications

- ❑ Shortness of breath
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Sleep Apnea
- ❑ Coughing up blood
- ❑ Sputum

Metabolic:

- ❑ Diabetes Type: _____
- ❑ Thyroid Disease
- ❑ Adrenal gland problems
- ❑ Steroid Use
- ❑ Metabolic Disorder

- ❑ Shunt, graft, fistula
- ❑ Dialysis
- ❑ Liver disease
- ❑ Gallbladder
- ❑ Hepatitis Type: _____
- ❑ Anemia
- ❑ Easy bruising or bleeding

Urinary:

- ❑ Frequency/Urgency
- ❑ Burning/Pain
- ❑ Blood in urine
- ❑ incontinence

Neurological:

- ❑ Epilepsy or seizures
- ❑ Fainting spells or dizziness
- ❑ Stroke
- ❑ Neuropathy
- ❑ Headaches / Migraines

Gastrointestinal:

- ❑ Ulcers, heartburn, reflux
- ❑ GERD
- ❑ Diverticulitis or Colitis
- ❑ Cancer
- ❑ Difficulty swallowing
- ❑ Constipation/Diarrhea

Skin:

- ❑ Rashes
- ❑ Lumps
- ❑ Itching/Dryness
- ❑ Hair loss/nail changes
- ❑ Color changes
- ❑ MRSA

Ears/Nose/Throat:

- ❑ Decreased hearing
- ❑ Earache/Ringing
- ❑ Stuffy/Runny nose
- ❑ Nosebleeds
- ❑ Dry mouth
- ❑ Sore throat
- ❑ Difficulty swallowing
- ❑ Hoarseness

Musculoskeletal:

- ❑ Muscle pain
- ❑ Joint pain
- ❑ Stiffness
- ❑ Redness of joints
- ❑ Swelling of joints
- ❑ Neck Pain
- ❑ Back pain
- ❑ Gout

Psychiatric:

- ❑ Stress/Anxiety
- ❑ Depression
- ❑ Mood changes
- ❑ Memory loss
- ❑ Substance abuse
- ❑ Post Traumatic Stress Disorder (PTSD)
- ❑ Psychosis
- ❑ Attention Deficit Hyperactive Disorder (ADHD)
- ❑ Other _____

Therapies you have tried in the past:

- ❑ Acupuncture
- ❑ Facet blocks
- ❑ Surgery
- ❑ Ablations
- ❑ Gel injections
- ❑ Stellate Ganglion blocks
- ❑ Implanted pain pump

- ❑ Massage
- ❑ Trigger point injections
- ❑ Implanted Spinal Cord Stimulator
- ❑ Implanted Dorsal Rood Ganglion Stimulator
- ❑ Heat/Ice application

- ❑ Chiropractor
- ❑ Support brace
- ❑ Tens unit
- ❑ Epidural injections
- ❑ Botox
- ❑ Radiofrequency

Are you on any blood thinners? ❑ Yes ❑ No

If yes, which blood thinners are you taking?

- ❑ COUMADIN ❑ PLAVIX ❑ PRADAXA ❑ AGGRENOX ❑ ELOQUIS
- ❑ XARELTO ❑ PETAL ❑ TICLID ❑ EFFIENT ❑ BRILINTA
- ❑ OTHER: _____

FOR OFFICE USE ONLY

Bp____/_____ HR_____ SpO2_____% RR_____ T____ Hight_____ Weight_____ Pain Level_____/10

Pain Location/Complaint: _____

Jaffe Ethical Addiction & Pain Care LLC

MEDICAL RELEASE OF INFORMATION (HIPPA RELEASE FORM)

HIPAA (Health Insurance Portability and Accountability Act) is Public Law 104-191, enacted in 1996, with its core regulations, including the Privacy Rule, Security Rule, and Breach Notification Rule, codified primarily in **Title 45 of the Code of Federal Regulations (CFR), Parts 160, 162, and 164**, governing the protection and electronic exchange of health information. The legal code mandates standards for health data privacy, security, electronic transactions, and patient rights, enforced by the HHS Office for Civil Rights (OCR).

Patients Name: _____ Date of Birth: _____

Adress: _____ Social Security Number: _____

Phone: _____ Email: _____

MEDICAL RECORDS: I hereby authorize _____ to disclose the following:

- ❑ **ALL MEDICAL RECORDS,** I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (PHI) protected under HIPAA.
- ❑ Restrictions – Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STD's or HIV/AIDSS shall: [ ] Be included [ ] Not be included.
- ❑ Limitations/Specific Medical Records: _____

RECIPIENT: My medical records shall be disclosed to the following individual/entity:

Dr/ Todd Jaffe, MD / Jaffe Ethical Addiction & Pain Care, LLC 5021 Evergreen Lane, Suite C, Show Low Arizona 85901
Ph: 928-892-5776 Fax: 928-495-5514

Email: info@jaffepaincare.com

Purpose of Release: Transfer of care, establish care, permanent. Expiration: This authorization expires after production of all records requested.

By signing below, I acknowledge that I understand that signing this authorization is voluntary, and that my treatment will not be conditioned upon whether I sign the authorization. I also understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where disclosure my have already been made based upon my original permission. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I will receive a copy of this authorization after have I have signed it and upon request. A copy of this authorization is as valid as the original.

Patient *Printed* Name or Legal Representative: _____ Date of Brith: _____

Patient or Legal Representative Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

Jaffe Ethical Addiction & Pain Care LLC

MEDICAL COMMUNICATION OF INFORMATION (HIPPA COMMUNICATION FORM)

HIPAA (Health Insurance Portability and Accountability Act) is Public Law 104-191, enacted in 1996, with its core regulations, including the Privacy Rule, Security Rule, and Breach Notification Rule, codified primarily in **Title 45 of the Code of Federal Regulations (CFR), Parts 160, 162, and 164**, governing the protection and electronic exchange of health information. The legal code mandates standards for health data privacy, security, electronic transactions, and patient rights, enforced by the HHS Office for Civil Rights (OCR).

Patients Name: _____ Date of Birth: _____

Adress: _____ Social Security Number: _____

Phone: _____ Email: _____

COMMUNICATION/RELEASE OF INFORMATION:

- ❑ I hereby authorize the release of information, including the diagnosis; records; examination rendered to me and insurance claims information. This information may be released to:
  - Spouse: _____
  - Child(ren): _____
  - Other: _____
  - Information is NOT to be released to anyone.

This Release of information will remain in effect until terminated by me in writing.

_____

MESSAGES:

Please call [ ] my Mobile [ ] my Home [ ] my work

Number to call: _____

If unable to reach me:

- ❑ You may leave a detailed message
- ❑ Please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Patient *Printed* Name or Legal Representative: _____ Date of Brith: _____

Patient or Legal Representative Signature: _____ Date: _____

Jaffe Ethical Addiction & Pain Care LLC

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.

Jaffe Ethical Addiction & Pain Care is committed to protecting your medical information. Further, we are required by law to maintain the privacy of your protected health information (PHI) and to give you this notice, explaining our legal duties and privacy practices with regards to your protected health information. We are required to abide by the terms set forth in this notice. We reserve the right to change the terms of this notice and to make the new provisions effective for all protected health information we maintain Any revisions will be posted in a prominent location in our office and, upon request, a copy will be provided to you of the revised notice.

Uses and Disclosures of Your Protected Health Information:

(1) **Treatment:** Your PHI may be used to provide, coordinate, or manage your health care and any related services. We may also disclose your PHI to other health care providers who may be treating you or involved in your health care to ensure they have the necessary information to diagnose, treat or provide a service.

(2) **Payment:** Your PHI may be used and disclosed to obtain payment for health care services provided by us or to determine whether we may obtain payment for services recommended for you. Your PHI may be disclosed to obtain payment or for payment activities from you, a health plan, healthcare clearing house, or a third Party. As an example, we may need to include information that identifies you, your diagnosis, procedures performed, with a bill to a third-party or your health plan to agree to payment for that treatment.

(3) **Health Care Operations:** We may use and disclose your PHI to support the business activities of our office. The activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians, medical students and other authorized personnel for educational and learning purposes. As an example, we may use your protected to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may also disclose your protected health information to third party business associates who perform certain activities for us (e.g., billing and transcription services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

(4) **Appointment Reminders/Treatment Alternatives/Health-Related Services:** We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of use to you.

(5) **Persons Involved in Your Care:** We may use and disclose to a family member, a relative, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgement.

(6) **Notification:** We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.

(7) **As required by Law:** We will disclose your PHI when required to do so by international, federal, state or local law. Examples Include:

- ☐ Public health activities including reporting of certain communicable diseases,
- ☐ Worker' compensation or similar programs as required by law,
- ☐ Authorities when we suspect abure, neglect, or domestic violence,
- ☐ Health oversight agencies, including the Food and Drug Administration and Department of Health and Human Services,
- ☐ For certain judicial and administrative proceedings pursuant to and administrative order,
- ☐ Law enforcement purposes, legal proceedings,
- ☐ To avert a serious threat to your health and safety or that of others,
- ☐ For governmental purposes such as military service or for nation security; and
- ☐ In the event of an emergency or for disaster relief
- ☐ Inmates, during the course of providing care

(8) **Business Associates:** We may share your PHI with other individuals or companies that perform various activities on behalf of our office, such as after-hours telephone answering, quality assurance, or clinic research.

(9) **Marketing & any purpose which require the sale of your information:** These disclosures require your written authorization.

(10) **Any other Uses and Disclosures no recorded in the Notice** will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and her will no longer disclose your PHI, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS REALTED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR OFFICE AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE ILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

(1) **Copy of this Notice:** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

(2) **Inspect and Copy:** You have the right to inspect and copy your PHI that we maintain about you for as long as we maintain that information You may not inspect or copy psychotherapy notes; information compiled in the reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding; or PHI that is subject to lay that prohibits access to PHI. In some circumstances, you may have a right to review our denial. If you wish to inspect or copy your medical information, you must submit your request in writing to the attention of our office at the address listed below. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. Our office has up to 30 days to make your PHI available to you (fee may apply).

(3) **Request and Electronic Copy:** You have the right to request that an electronic copy of your PHI be given to you or transmitted to your designated officer. We will make every effort to provide the electronic copy in the format you request, however if it is not readily produceable by us we will provide it in either our standard format or in a hard copy form (fee may apply).

(4) **Request Restrictions:** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. You may ask us not to use or disclose any part of your PHI and by law we must comply when the PHI pertains solely to health care items or services for which the health care provider involved has been paid out of pocket in full. Requests must be made in writing to our office with instructions. If we agree to the restriction, we may only be in violation of the restriction for emergency treatment purposes. By law, you may not request we restrict the disclosure of your PHI for treatment purposes.

(5) **Right to Receive Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.

(6) Request Amendments: If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be done in writing to the office as listed below. In certain cases we may deny your request. If we deny your request 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 a copy.

(7) **Request Accounting of Disclosures:** You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set; that occurred before October 1, 2025, or 6 years from the date of the request. Your request must be in writing and must state the time period for the requested information. Your first request for a list of disclosures within a 12-month period will be free. I you request an additional list withing 12-months of the first request, we may charge you a fee for the costs if providing the subsequent list, We will notify you of such costs ad afford you the opportunity to withdraw your request before any costs are incurred.

(8) **Request Restrictions:** You have the right to request that we communicate only with you in certain ways to preserve your privacy. For example, you may request that we contact your by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where to contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

(9) **Request a Copy of Notice:** You have the right t request that we provide you with a paper copy of this Notice of Privacy Practices.

(10) **File a Complaint:** You have the right to file a complaint with our office or with the Secretary of the Department of Health and Human Services sif you believe we have violated your privacy rights. Complaints to our office must be in writing. We will not retaliate against your for filing a complaint.

(11) If you have questions about this notice or would like additional information, please contact our office at:

Jaffe Ethical Addiction & Pain Care, LLC 5021 Evergreen Lane, Suite C, Show Low Arizona 85901 Ph: 928-892-5776 Fax: 928-495-5514

By signing below, I acknowledge that I have received the Notice of Privacy Practices at this office, which outlines how patient confidential information will be used, disclosed, and protected. I understand that I may refuse to sign this Acknowledgement.

Patient Printed Name or Legal Representative: _____ Date of Brith: _____

Patient or Legal Representative Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain a written acknowledgement of this Notice of Privacy Practices but could not because:

_____ Individual refused to sign _____ Communication Barrier _____ Care Providd was Emergent _____ Other

Employee Initials _____ Date: _____

Jaffe Ethical Addiction & Pain Care LLC

NOTICE OF PATIENT'S RIGHTS

This information is to inform the patient or the patient's representative, or surrogate of the patient's right and the clinic must protect and promote the exercise of these rights by following the patient's rights that are listed in this document.

Jaffe Ethical Addiction & Pain Care observes and respect's a patient's rights and responsibilities without regard to age, race, color, sex, gender, sexual orientation, disability, marital status, or diagnosis, national origin, religion, culture, physical or mental being, economic status, personal values or belief system. The patient has the right to exercise his or her rights without subject to discrimination nor reprisal: to voice grievance regarding treatment or cate that is, or fails to be, furnished; and to the confidentiality of personal medical information. The patient has the right to personal privacy, to receive care in a safe setting and to be free of all forms of abuse and harassment.

THE ADMINISTRATOR WILL ENSURE THAT THE PATIENT HAS THE RIGHT TO:

- Be treated with dignity, respect and consideration
- Not be subjected to (1) abuse (2) neglect (3) exploitation (4) coercion (5) manipulation (6) sexual abuse (7) sexual harassment (8) except as allowed in R9-10-1012(8) (if necessary to prevent harm to self or others) restrain or seclusion (9) retaliation for submitting a complaint to the Department of Health and Human Services or another entity; or (10) misappropriation of personal and private property by an outpatient clinic's personnel member, employee, volunteer or student; the Patient or the Patient's representative: except in an emergency, either consents to or refuses treatment
- May refuse or withdraw consent to treatment before treatment is initiated
- Except in an emergency, either consents to or refuses treatment
- May refuse or withdrawal consent to treatment before treatment is initiated
- Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and the associated risks and possible complicates of the proposed psychotropic medication or surgical procedure.
- Is informed of the following: (1) Jaffe's Ethical Addiction & Pain Care's Policy on health care directive, and (2) the patient complaint process
- Consents to photographs of the patient may be photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes only; and
- Except as otherwise permitted by law, it provides written consent to the release of the patient's medical records and financial records
- A Patient has the following rights:
    - Not to be discriminated against based on age, race, color, sex, gender, sexual orientation, disability, marital status, or diagnosis, national origin, religion, culture, physical or mental being, economic status, personal values or belief system
    - To receive treatment that supports and respect the patient's individuality, choices, strengths and abilities
    - To receive privacy in treatment and care of personal needs
    - To review, upon request, the patient's own medical record according to ARS 12-2293, 12-2294, and 12-294.01
    - To review our state survey results from the ADHS upon request
    - Patient reserves the right to review, upon request, a copy of our current fee schedule
    - Receive a referral to another health care institution if the outpatient treatment is not authorized or unable to provide physical health services needed by the patient
    - To participate or have the patient's representative participate in the development of, or decisions concerning treatment
    - To participate or refuse to participate in research or experimental treatment and;
    - To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting or exercising the patient's rights.

AZ DEPARTMENT OF HEALTH & HUMAN SERVICES – 150 N 18th Ave $450, Phoenix AZ 85007, 602-364-3030

If you have questions about this notice or would like additional information, please contact our office at:

Jaffe Ethical Addiction & Pain Care, LLC 5021 Evergreen Lane, Suite C, Show Low Arizona 85901 Ph: 928-892-5776 Fax: 928-495-5514

By signing below, I acknowledge that I have received the Notice of Patient's Rights at this office, which outlines how patient confidential information will be used, disclosed, and protected. I understand that I may refuse to sign this Acknowledgement.

Patient Printed Name or Legal Representative: _____ Date of Brith: _____

Patient or Legal Representative Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain a written acknowledgement of this Notice of Patient's Rights but could not because:

_____ Individual refused to sign _____ Communication Barrier _____ Care Providd was Emergent _____ Other

Employee Initials _____ Date: _____