Simi Ahuja, MD

Redesigning Your DNA

Welcome to Dr. Simi's Holistic Practice. Dr. Simi provides integrative health that encompasses multiple disciplines. She specializes in Family Practice and blends that with Functional Medicine along with Mind Body Medicine for those that are willing to make meaningful positive changes in their health. This delivery of health is incredibly unique and potent. She uses the physiology of Family Practice, incorporates biochemistry in a way that will help you to set a solid foundation for the Mind Body work. Mind Body work entails Subcellular Psychobiology. Simply put it is the power of psychology to affect biology including immunology. Psycho-biology is the frontier of medicine. While it may take decades for research to catch up to what Dr. Simi knows, she has the tools right here and now to be able to assist you with even your "incurable" diseases. The type of care she provides is for everyone but only offered to those that are prepared to work and want to stay accountable to treatment recommendations. Her job is to help you implement important clinical platforms to ensure your long-term success. Your job is to do the work. So, let's get started.

Financial Office Policy and Treatment Expectations

We appreciate the opportunity to provide you with the highest quality in natural health care for all ages. As your health is as important to us as it is to you, we appreciate you taking the time in filling out your comprehensive health history form. You will notice that this form is extensive and detailed. You may find this form on our website http://drsimiahuja.com/. We ask that you take some time with this form and fill it out without distractions. Attached to this form is a 4-day diet diary that will need to be filled out as well. So, it is best to fill this out about a week before your scheduled first visit. You may want to carry this diet diary around with you as it has been our experience that it is much easier to remember what you have consumed if you write it down immediately. Please make sure to fill this form out in detail prior to coming to your appointment.

With your first appointment be assured that you will receive Dr. Simi's undivided attention as she takes a thorough history as the quality of the interview, history and examination is directly proportional to the quality of health care provided. This is also needed to best decide what treatment recommendations are best suited for you individually.

Generally, internal disorders (thyroid, autoimmunity, diabetes, obesity, fatigue, fibromyalgia, hormones etc.) are labels for a progressive, time dependent, depletion of important metabolic reserves. It takes time to get sick. Thus, it takes time to heal. We want you to understand that helping lift someone out of a chronic disease state is a process. There is no easy button. It requires a commitment by the patient and a health guide (doctor). It also requires the application of medically integrated protocols that utilize a multidisciplinary approach. True healing can only be accomplished through therapeutic strategies that are not about controlling symptoms but by shifting and preserving underlying metabolic reserves into a more positive direction. This is done by incorporating known principles of health to help identify the root cause of dis-ease and not covering up or altering metabolic processes of the body with a pill.

The mind and body are capable of healing very quickly when given the correct nurturing interventions.

If you elect to become a patient and we agree to accept your condition, you will need to understand and agree to follow through with recommendations. This process will take time and involves, in some cases, multiple providers. You will need to acknowledge that there will be a financial commitment as well and that insurance may or may not be helpful. We do not accept the limiting beliefs, policies, and guidelines of insurance policies.

***Patient Signature**_____ **Date**_____

By signing above, I understand the information stated and agree to the guidelines noted. I also understand that the above guidelines may not be exact to my case or situation. Guidelines are meant to generally advise you of treatment and financial expectations. Because of the biodiversity of human physiology, we cannot predict with any degree of medical certainty, how well you will respond to treatment, but we will do our best to guide you through the journey in a holistic way.

Financial/Consent Policies

Dr. Simi is committed to providing you with the best general, preventative, and complimentary medical care. The following information outlines financial responsibilities related to payment for professional services.

Financial Responsibility and Insurance

You, the undersigned patient is ultimately responsible for all charges associated with your care regardless of insurance coverage. We require payment at the time of service unless previous arrangements have been made. If you request, documentation we will be provided to you to submit to your insurance for consideration of reimbursement. Your insurance company may deny payment for non-contracted services. These services may include but not limited to medical, chiropractic, acupuncture, preventative medicine procedures, massage therapy, physical therapy, nutritional recommendations, and supplements. Before starting medical services and treatment at your first visit we will require a copy of your driver's license or state issued identification card. If you have any questions about this policy, please feel free to call us at 303.665. 2525. Your signature below indicates that you have read and agree to this Financial Policy.

_____ We require payment for office visits that require the doctor's time (review labs, disability forms, FLMA paperwork, and medical visits) at the time of service. We accept checks, Visa, Master Card, Cash, FSA and HSA plans. We also accept Care Credit.

Initial

_____ Payment arrangements will be handled through Care Credit. Payments through Care Credit will require a separate agreement that does not involve Dr. Simi. You may discuss this with our office manager during normal business hours.

Initial

Treatment of a Minor

If the patient is a minor (under the age of 18), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, and providing required referrals, and picture ID cards.

_____ We can discuss only billing information (no medical information) on an account for a patient over 18 years of age, regardless if the patient's parent, guardian of the subscriber is financially responsible.

Initial

Cancellation and Missed Appointment Policy

We require a minimum of **24 business hours'** notice when a patient cancels or reschedules their appointment**. New patient appointments will be subject to a fee of 80% of the value of the visit.** When a patient does not show up for an appointment or cancels/reschedules with less than 24 business hours' notice, a fee will be applied to the patients account based on the following schedule:

New Patient appointments - 80% of the value of the visit; no warning available.
Established patients are allowed one reminder in a 12-month period at no charge, then:
$25.00 fee for a second offense. $50.00 fee for a third offense.

Credit card number will be required to schedule future appointments and charged at full cost if the appointment is cancelled/rescheduled.

_____ Checks returned for "not sufficient funds" - $50.00.

Medicare Patients – We do not participate in Medicare or Tricare insurance programs.

The only covered service provided by a participating chiropractor to a Medicare Beneficiary is manipulation of the spine. We are not a participating provider for Medicare. If you are a Medicare participant, we **do not** provide manipulation to you as covered service. We would be more than happy to refer you to a provider that accepts Medicare participants. We do accept cash for non-covered Medicare services.

Medicaid Patients - Medicaid does not cover any of our services. We do accept cash for non-covered Medicaid services.

Refund Policy There are no refunds available for any laboratory once they have been submitted to the lab. If you need to terminate your care early, we will work with you on a pro-rated amount with considerations to the doctors time only.

Agreement/Consent

I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I understand the above information and guarantee the Intake/Welcome form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

This is the entire agreement/consent between Dr. Simi and the patient below. Policy is subject to change without notice. I have read this agreement, understand it and agree with its provisions.

Patient Name_____ Date _____

Responsible Party Signature _____ Date _____

Witness_____ Date _____

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Dr. Simi Ahuja, M.D.
304 W. Baseline Rd.
Lafayette, CO 80026
303-665-2525
www.drsimiahuja.com

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Date of Birth_____

Signature_____

Date_____

The Privacy Rule protects individually identifiable health information from uses and disclosures that unnecessarily compromise the privacy of an individual. The Rule is carefully designed to protect the privacy of health information, while allowing important health care communications to occur.

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GENERAL INFORMATION

(If more space is needed when filling in certain sections, please feel free to provide separate sheet)

Name: *First*_____ *Middle*_____ *Last*_____

Preferred Name:_____ Date:_____

Date of Birth: _____/_____/_____Age: _____Gender: □ Male □ Female

Primary Address: _____Apt. No.: _____

City: _____State: _____

_____Zip: _____

Alternate Address: _____Apt. No.: _____

City: _____State: _____Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Best Phone and Times to Reach You: _____

Email: _____Fax: _____

Emergency Contact: Name _____Phone_____

Relationship to you_____Address: _____

City: _____State: _____Zip: _____

Your Genetic Background: □ African □ Asian □ European □ Ashkenazi □ Native American □ Middle Eastern □ Mediterranean □ Other _____ Highest Education Level: □ High School or Equivalent

□ Graduate□ Post-Graduate

Job Title: _____

Nature of Business: _____

Whom may we thank for referring you? _____

□ Website □ Media □ Other _____

Insurance Information Reminder

Dr. Simi is not in network with any insurance company. We do not bill directly to any insurance carrier. However, they may cover many our services. We can provide a billing statement that you can submit to your insurance company for consideration of reimbursement.

Payment Information

Payment is due at time of service, no exceptions unless previous arrangements have been made. If you would like to submit a claim for payment of services to your insurance company, we will provide you with a statement to submit to your insurance company. Knowledge and awareness of insurance coverage is the sole responsibility of the patient.

Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

Health Concern or Goal #1 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #3 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions*: _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition?

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

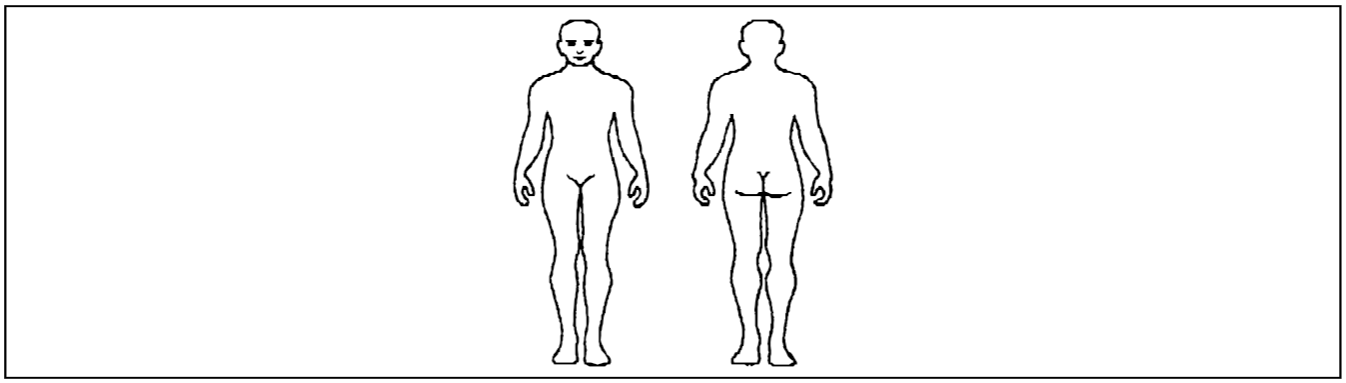
In general, what do you hope to achieve with your visits here? _____

_____

_____

When was the last time you felt exceptionally well? _____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box



Other comments you think are important _____

_____

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

□ Doctor of Chiropractic *Name:* _____ *City:* _____

Treatment Focus: _____

□ M.D./D.O. *Name:* _____ *City:* _____

Treatment Focus: _____

□ Physical Therapist *Name:* _____ *City:* _____

Treatment Focus: _____

□ Acupuncture *Name:* _____ *City:* _____

Treatment Focus: _____

□ *Other:* _____

Name: _____ *City:* _____

Treatment Focus: _____

Medical History *continued*

Hospitalizations □ None

*Date*_____- *Reason* _____

_____- _____

_____- _____

_____- _____

Allergies

Medication/Supplement/Food	*Reaction*

Diseases/Diagnosis/Conditions: *Check appropriate box and provide Month/Year of onset* □ *Past Condition* □ Ongoing *Condition*

Gastrointestinal
- □ □ Irritable Bowel Syndrome ___/____
- □ □ Inflammatory Bowel Disease ___/____
- □ □ Crohn's ___/____
- □ □ Ulcerative Colitis ___/____
- □ □ Gastritis or Peptic Ulcer Disease ___/____
- □ □ GERD *(reflux)* ___/____
- □ □ Celiac Disease ___/____
- □ □ Hemorrhoids ___/____
- □ □ Other ___/____ _____

Cardiovascular
- □ □ Heart Attack ___/____
- □ □ Other Heart Disease ___/____
- □ □ Stroke ___/____
- □ □ Elevated Cholesterol ___/____
- □ □ Arrhythmia *(irregular heart rate)* ___/____
- □ □ Hypertension *(high blood pressure)* ___/____
- □ □ Rheumatic Fever ___/____
- □ □ Mitral Valve Fever ___/____
- □ □ Other ___/____ _____

Cancer
- □ □ Lung Cancer ___/____
- □ □ Breast Cancer ___/____
- □ □ Colon Cancer ___/____
- □ □ Ovarian Cancer ___/____
- □ □ Prostate Cancer ___/____
- □ □ Skin Cancer ___/____
- □ □ Other ___/____ _____

Genital & Urinary Systems
- □ □ Kidney Stones ___/____
- □ □ Gout ___/____
- □ □ Interstitial Cystitis ___/____
- □ □ Frequent Urinary Tract Infections ___/____
- □ □ Frequent Yeast Infections ___/____
- □ □ Erectile or Sexual Dysfunctions ___/____
- □ □ Other ___/____ _____

Metabolic/Endocrine
- □ □ Type 1 Diabetes ___/____
- □ □ Type 2 Diabetes ___/____
- □ □ Hypoglycemia ___/____
- □ □ Metabolic Syndrome *(Insulin Resistance/ Pre-Diabetes)*___ /___
- □ □ Hypothyroidism *(low thyroid)* ___/____
- □ □ Hyperthyroidism *(overactive thyroid)* ___/____
- □ □ Endocrine Problems ___/____
- □ □ Polycystic Ovarian Syndrome *(PCOS)* ___/____
- □ □ Infertility ___/____
- □ □ Weight Gain ___/____
- □ □ Weight Loss ___/____
- □ □ Frequent Weight Fluctuations ___/____
- □ □ Bulimia ___/____
- □ □ Anorexia ___/____
- □ □ Binge Eating Disorder ___/____
- □ □ Night Eating Syndrome ___/____
- □ □ Eating Disorder *(non-specific)* ___/____
- □ □ Other ___/____ _____

Musculoskeletal/Pain
- □ □ Osteoarthritis ___/____
- □ □ Fibromyalgia ___/____
- □ □ Chronic Pain ___/____
- □ □ Tendonitis ___/____
- □ □ Tension Headaches ___/____
- □ □ TMJ Problems ___/____
- □ □ Foot Cramps ___/____
- □ □ Joint Deformity ___/____
- □ □ Joint Pain ___/____
- □ □ Other ___/____ _____

Diseases/Diagnosis/Conditions: *continued*

Inflammatory/Autoimmune
- □ □ Chronic Fatigue Syndrome ___/____
- □ □ Autoimmune Disease ___/____
- □ □ Rheumatoid Arthritis ___/____
- □ □ Lupus SLE ___/____
- □ □ Immune Deficiency Disease ___/____
- □ □ Herpes-Genital ___/____
- □ □ Cold Sores ___/____
- □ □ Severe Infectious Disease ___/____
- □ □ Poor Immune Function *(frequent infections* ___/____
- □ □ Food Allergies ___/____
- □ □ Environmental Allergies ___/____
- □ □ Multiple Chemical Sensitivities ___/____
- □ □ Latex Allergy ___/____
- □ □ Other ___/____ _____

Respiratory Diseases
- □ □ Asthma ___/____
- □ □ Chronic Sinusitis ___/____
- □ □ Bronchitis ___/____
- □ □ Emphysema ___/____
- □ □ Pneumonia ___/____
- □ □ Tuberculosis ___/____
- □ □ Sleep Apnea ___/____
- □ □ Other ___/____ _____

Head, Eyes, & Ears
- □ □ Conjunctivitis ___/____
- □ □ Distorted Sense of Smell ___/____
- □ □ Distorted Taste ___/____
- □ □ Ear Fullness ___/____
- □ □ Ear Pain ___/____
- □ □ Hearing Loss ___/____
- □ □ Hearing Problems ___/____
- □ □ Headache ___/____
- □ □ Migraine ___/____
- □ □ Sensitivity to Loud Noises ___/____
- □ □ Vision Problems *(other than glasses)* ___/____
- □ □ Macular Degeneration ___/____
- □ □ Vitreous Detachment ___/____
- □ □ Retinal Detachment ___/____
- □ □ Other ___/____ _____

Nails
- □ □ Bitten ___/____
- □ □ Brittle ___/____
- □ □ Curve Up ___/____
- □ □ Frayed ___/____
- □ □ Fungus-Fingers ___/____
- □ □ Fungus-Toes ___/____
- □ □ Pitting ___/____
- □ □ Ragged Cuticles ___/____
- □ □ Ridges ___/____
- □ □ Soft ___/____
- □ □ Thickening of Finger Nails ___/____
- □ □ Thickening of Toenails ___/____
- □ □ White Spots/Lines ___/____
- □ □ Other ___/____ _____

Skin Diseases
- □ □ Acne on Back ___/____
- □ □ Acne on Chest ___/____
- □ □ Acne on Face ___/____
- □ □ Acne on Shoulders ___/____
- □ □ Athlete's Foot ___/____
- □ □ Bumps on Back of Upper Arms ___/____
- □ □ Cellulite ___/____
- □ □ Dark Circles Under Eyes ___/____
- □ □ Ears Get Red ___/____
- □ □ Easy Bruising ___/____
- □ □ Lack of Sweating ___/____
- □ □ Hives ___/____
- □ □ Jock Itch ___/____
- □ □ Lackluster Skin ___/____
- □ □ Moles w/ Color/Size Change ___/____
- □ □ Oily Skin ___/____
- □ □ Pale Skin ___/____
- □ □ Patchy Dullness ___/____
- □ □ Rash ___/____
- □ □ Red Face ___/____
- □ □ Sensitive to Poison Ivy/Oak ___/____
- □ □ Shingles ___/____
- □ □ Skin Darkening ___/____
- □ □ Strong Body Odor ___/____
- □ □ Hair Loss ___/____
- □ □ Vitiligo ___/____
- □ □ Eczema ___/____
- □ □ Psoriasis ___/____
- □ □ Melanoma ___/____
- □ □ Skin Cancer ___/____
- □ □ Other ___/____ _____

Neurologic/Mood
- □ □ Depression ___/____
- □ □ Anxiety ___/____
- □ □ Bipolar Disorder ___/____
- □ □ Schizophrenia ___/____
- □ □ Headaches ___/____
- □ □ Migraines ___/____
- □ □ ADD/ADHD ___/____
- □ □ Autism ___/____
- □ □ Mild Cognitive Impairment ___/____
- □ □ Memory Problems ___/____
- □ □ Parkinson's Disease ___/____
- □ □ Multiple Sclerosis ___/____
- □ □ ALS ___/____
- □ □ Seizures ___/____
- □ □ Other Neurological Problems _____

Blood Type

□ A □ B □ AB □ O □ Rh+ □ unknown

Injuries

Check box if yes and provide date/description
- □ Back Injury ___/____ _____
- □ Head Injury ___/____ _____
- □ Neck Injury ___/____ _____
- □ Broken Bones __/____
- □ Other ___/____ _____

Diseases/Diagnosis/Conditions: *continued*

Female Reproductive
□ □ Breast Cysts ___/____
□ □ Breast Lumps ___/____
□ □ Breast Tenderness ___/____
□ □ Ovarian Cysts ___/____
□ □ Poor Libido ___/____
□ □ Vaginal Discharge ___/____
□ □ Vaginal Odor ___/____
□ □ Vaginal Itch ___/____
□ □ Vaginal Pain with Sex ___/____
□ □ Other ___/____ _____

Surgeries
Check box if yes and provide date of surgery
□ None
□ Appendectomy ___/____
□ Hysterectomy +/- Ovaries ___/____
□ Gall Bladder ___/____
□ Hernia ___/____
□ Tonsillectomy ___/____
□ Dental Surgery ___/____
□ Joint Replacement: Knee/Hip ___/____
□ Heart Surgery: Bypass Valve ___/____
□ Angioplasty or Stent ___/____
□ Pacemaker ___/____
□ Other ___/_____

Male Reproductive
□ □ Discharge from penis ___/____
□ □ Ejaculation Problem ___/____
□ □ Genital Pain ___/____
□ □ Impotence ___/____
□ □ Prostate or Urinary Infection ___/____
□ □ Lumps in Testicles ___/____
□ □ Poor Libido *(Sex Drive)* ___/____
□ □ Other ___/____ _____

Preventive Tests
Check box if yes and provide date of most recent test
□ Blood Tests ___/____
□ Full Physical Exam ___/____
□ X-Ray ___/____ *Body Part?*_____
□ Dental X-Ray ___/____
□ Bone Density ___/____
□ Colonoscopy ___/____
□ Cardiac Stress Test ___/____
□ EKG ___/____
□ Hemoccult Test (stool test for blood) ___/____
□ MRI ___/____
□ CT Scan ___/____
□ Upper Endoscopy ___/____
□ Upper GI Series ___/____
□ Ultrasound ___/____
□ Other ___/____ _____

Gynecologic History *(for women only)*

Obstetric History *Check box if yes and provide relevant quantity*
□ Pregnancy_____ □ Vaginal Delivery_____ □ Caesarean Delivery_____ □ Miscarriage_____ □ Abortion_____
□ Living Children_____ □ Post-Partum Depression_____ □ Toxemia_____ □ Gestational Diabetes_____
□ Baby over 8 lbs. _____ □ Premature_____□ Low Birth Weight (< 6lbs) _____
□ Breast Feeding Your Child *How long?* _____ □ Oral Contraceptives_____ *How long?* _____

Menstrual History
Age at first period: _____ Menses Frequency: _____ Length between menses: _____ Pain: □ Yes □ No
Clotting: □ Yes □ No Has your period ever skipped? □ Yes □ No How long? _____
Last Menstrual Period: _____
Do you use contraception? □ Yes □ No *If yes:* □ Condom □ Diaphragm □ IUD □ Partner Vasectomy

Women's Disorder s/Hormonal Imbalances
□ Fibrocystic Breasts □ Breast Cancer ___/___ □ Endometriosis □ Fibroids □ Infertility
□ Painful Periods □ Heavy Periods □ PMS
Last Mammogram ____/____ Anything Abnormal? _____□ Breast Biopsy ____/____
□ Thermogram ____/____/____ Last PAP Test ___/ ___/ ___ □ Normal □ Abnormal
Date of Last Bone Density: ___/___/____ Results: □ High □ Low □ Within Normal Range
Are you in menopause? □ Yes □ No Age of onset of menopause: _____
Check box if you are experiencing
□ Hot Flashes □ Mood Swings □ Concentration/Memory Problems □ Vaginal Dryness
□ Decreased Libido □ Heavy Bleeding □ Joint Pains □ Headaches □ Weight Gain
□ Loss of Control of Urine □ Palpitations □ Painful Intercourse
□ Use of hormone replacement therapy *How Long?* _____*What hormones and dosage?* _____

Men's History *(for men only)*

Have you had a PSA done? □ Yes □ No Date of last test? ___/___/_____Highest PSA Level: □ 0-2 □ 2-4 □ 4-10 □ >10

Check all that apply:

Do you regularly have morning erections? □ Yes □ No □ Increased fat accumulation □ Headaches
□ Emotional reactions □ Prostate enlargement □ Prostate infection □ Change in libido □ Impotence
□ Difficulty obtaining an Erection □ Difficulty maintaining an erection □ Prostate Cancer
□ Nocturia *(urination at night)* How many times a night? _____ □ Urgency/Hesitancy/Change in Urinary Stream
□ Loss of Control of Urine □ Testicular injury □ Testosterone replacement □ More fatigue and/or muscle soreness

Medications

Current Medications *(Both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Previous Medications*: Last 10 Years*

Medication	Dose	Frequency	Start Date (month/year)	End Date (month/year)	Reason For Use

Nutritional Supplements: *(Vitamins, Minerals, Herbs, &Homeopathy)* *If more space is needed, please write on separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No

Describe: _____

Have you had prolonged *(3 days or longer)* or regular use of NSAIDS *(i.e. Advil, Aleve, Motrin, Aspirin, etc.)*? □ Yes □ No
Have you had prolonged or regular use of Tylenol? □ Yes □ No
For what reason, and for how long, did you use pain relievers? _____
How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____
Have you had prolonged or regular use of Acid Blocking Drugs *(i.e. Tagamet, Zantac, Prilosec, etc.)*? □ Yes □ No
Have you taken antibiotics **more than** 1 x per year? □ Yes □ No
Have you had long-term use of antibiotics? *(More than 10 days.)* □ Yes □ No
How many times have you taken antibiotics throughout your lifetime? _____
Have you ever used steroids *(i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.)*? □ Yes □ No

GI History

Foreign travel? □ Yes □ No *Where?* _____
Wilderness Camping □ Yes □ No *Where?* _____
Have you had severe: □ Gastroenteritis □ Diarrhea □ Crohn's/Ulcerative colitis □ Parasites
Do you feel like you digest your food well? □ Yes □ No Do you feel bloated after meals? □ Yes □ No

Patient Birth History

□ Term □ Premature *Pregnancy Complications:* _____
Birth Complications: _____
□ Breast Fed *How long?* _____ □ Bottle-fed
Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____
Did you eat candy or sugar as a child? □ Yes □ No

Dental History

Dental Surgery? _____
□ Silver Mercury Fillings *How many?* _____ □ Gold Fillings □ Root Canals □ Implants □ Tooth Pain
□ Bleeding Gums □ Gingivitis □ Problems with Chewing
Do you floss regularly? □ Yes □ No Do you brush regularly? □ Yes □ No
What toothpaste do you use? _____ Have you had Fluoride treatments? □ Yes □ No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? □ Yes □ No *If yes, describe symptoms and list all foods:*
_____
_____
Do you have an adverse reaction to caffeine? □ Yes □ No
When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains □ Headaches
Do you adversely react to: *Check all that apply*
□ Monosodium Glutamate *(MSG)* □ Aspartame *(NutraSweet)* □ Preservatives *(ex. sodium benzoate)*
□ Cheese □ Citrus foods □ Chocolate □ Alcohol □ Red Wine □ Caffeine □ Bananas □ Garlic □ Onion
□ Sulfite containing foods *(wine, dried fruit, salad bars)* □ Other: _____

Environmental & Detoxification Assessment

Which of these significantly affect you? *Check all that apply*

□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other:
In your home or work environment, are you exposed to: □ Chemicals □ Electromagnetic Radiation □ Mold
How often do you use your cell phone? _____ $^{hrs}/_{day}$ How often do you use your computer? _____ $^{hrs}/_{day}$ _____ $^{hrs}/_{wk}$
Have you ever turned yellow *(jaundiced)*? □ Yes □ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? □ Yes □ No
If yes, explain _____
Do you have a known history of significant exposure to any harmful chemicals such as the following:
□ Herbicides □ Insecticides *(frequent visits of exterminator)* □ Pesticides □ Organic Solvents
□ Heavy Metals □ Other _____
Chemical *Name/Date/Length of Exposure (if known)* _____
Do you dry clean your clothes frequently? □ Yes □ No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? □ Yes □ No
Do you have any pets or farm animals? □ Yes □ No
What detergents/soaps do you use *(Brand names)*? _____
What deodorant? _____
What beauty products do you use *(Lotions, Hair products, Make-up, etc.)*? _____

Family History

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age *(if still alive)*												
Age at Death *(if deceased)*												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis *(Rheumatoid, Psoriatic, Ankylosing Spondylitis)*												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases *(such as Lupus)*												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse *(such as Alcoholism)*												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
Other:												

Social History

Weight Stats

Height _____*ft.* _____*in.* Current Weight _____ Usual Weight Range *(+/- 5lbs)* _____
Desired Weight Range *(+/- 5lbs)* _____ Highest Adult Weight _____ Lowest Adult Weight _____
Have you experienced weight fluctuations greater than 10 lbs? □ Yes □ No Body fat % _____
Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing describe* _____
_____

Nutrition History

Have you ever had a nutrition consultant? □ Yes □ No
Have you made any changes in your eating habits because of your health? □ Yes □ No *Describe* _____
_____
Do you currently follow a special diet or nutritional program? □ Yes □ No *Check all that apply*
□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy □ No Wheat
□ Gluten Restricted □ Vegetarian □ Vegan □ Ultrametabolism □ Macrobiotic □ Paleo
□ Specific Program for Weight Loss/Maintenance Type: _____ □ Other _____
How often do you weigh yourself? □ Daily □ Weekly □ Monthly □ Rarely □ Never
Have you ever had your metabolism *(resting metabolic rate)* checked? □ Yes □ No *If Yes, what was it?* _____
Do you avoid any particular foods? □ Yes □ No If yes, types & reason _____
_____
If you could only eat a few foods a week, what would they be? _____
_____
Do you grocery shop? □ Yes □ No If no, who does the shopping? _____
Do you eat organic foods? □ Yes □ No
What percentage of your food is organic (pesticide free, non-GMO, etc.)? _____
How many meals do you eat out per week? □ 0 – 1 □ 1 – 3 □ 3 – 5 □ >5 meals per week
Check all factors that apply to your current lifestyle and eating habits

□ Fast Eater
□ Erratic eating pattern
□ Eat too much
□ Late night eating
□ Dislike healthy food
□ Time constraints
□ Eat more than 50% meals away from home
□ Travel frequency
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience
□ Poor snack choices
□ Significant other or family members don't like healthy foods
□ Significant other or family members have special dietary needs or food preferences
□ Love to eat
□ Eat because I have to
□ Have a negative relationship to food
□ Struggle with eating issues
□ Emotional eater *(eat when sad, lonely, depressed, bored)*
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Eating in the middle of the night
□ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____
_____
What foods would be the hardest to reduce or eliminate? _____

Smoking

Currently smoking? □ Yes □ No *How many years?* _____ *Packs per day:* _____ *Attempts to quit:* _____
Previous smoking? *How many years?* _____ *Packs per day:* _____ *Date quit:* _____
Secondhand smoke exposure? _____ *From where?* _____

Social History *continued*

Alcohol Intake

How many drinks currently per week? *1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit*

□ None □ 1 -3 □ 4 – 6 □ 7 – 10 □ > 10 If 'None' – Skip to 'Other Substances'

Most common beverage? _____

Have you ever been told you should cut down your alcohol intake? □ Yes □ No

Do you get annoyed when people ask you about your drinking? □ Yes □ No

Do you ever feel guilty about your alcohol consumption? □ Yes □ No

Do you ever take an eye-opener? □ Yes □ No

Do you notice a tolerance to alcohol? *(Can you 'hold' more than others?)* □ Yes □ No

Have you ever been unable to remember what you did during a drinking episode? □ Yes □ No

Do you get into arguments or physical fights when you have been drinking? □ Yes □ No

Have you ever been arrested or hospitalized because of drinking? □ Yes □ No

Have you ever thought about getting help to control or stop your drinking? □ Yes □ No

Other Substances

Caffeine intake: □ Yes □ No Cups/day: □ Coffee □ Tea - □ 1 □ 2 – 4 □ > 4 a day

Caffeinated sodas or diet sodas intake: □ Yes □ No

12 oz. soda per day: □ 1 □ 2 – 4 □ > 4 a day Favorite soda: _____

Are you currently using any recreational drugs? □ Yes □ No *Type* _____

Have you ever used IV or inhaled recreational drugs? □ Yes □ No

Exercise

Current exercise program

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other *(Yoga, Pilates, Gyrotonics, etc.)*			
Sports or Leisure Activities *(Golf, Tennis, Rollerblading, etc.)*			

Rate your level of motivation for including exercise in your life? □ Low □ Medium □ High

List your problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? □ Yes □ No *If yes, please describe:* _____

_____

Do you usually sweat when exercising? □ Yes □ No

Psychosocial

Do you feel significantly less vital than you did a year ago? □ Yes □ No

Are you happy? □ Yes □ No Do you feel your life has meaning and purpose? □ Yes □ No

Do you believe stress is presently reducing the quality of your life? □ Yes □ No

Do you like the work you do? □ Yes □ No Have you ever experienced major losses in your life? □ Yes □ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? □ Yes □ No

Would you describe your experience as a child in your family as happy and secure? □ Yes □ No

Social History *continued*

Stress / Coping

Have you ever sought counseling? □ Yes □ No *Describe* _____

Are you currently in therapy? □ Yes □ No *Describe* _____

Do you feel you have an excessive amount of stress in your life? □ Yes □ No

Do you feel you can easily handle the stress in your life? □ Yes □ No

How do you deal with stress? _____

Daily Stressors: *Rate on a scale of 1 – 10* Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you practice meditation or relaxation technique? □ Yes □ No *How often?* _____

Check all that apply □ Yoga □ Meditation □ Imagery □ Breathing □ Tai Chi □ Prayer

□ Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? □ Yes □ No

If yes, please explain _____

Do you regularly give gratitude for everything in your life? □ Yes □ No

How would you describe your overall attitude towards life? _____

Do you have a spiritual practice? □ Yes □ No *Describe* _____

Sleep / Rest

Average number of hours you sleep per night: □ > 10 □ 8 -10 □ 6 – 8 □ < 6

What time do you typically go to sleep? _____:_____ $^{AM}/_{PM}$ Do you have trouble going to sleep? □ Yes □ No

Do you feel rested upon awakening? □ Yes □ No Do you have problems with insomnia? □ Yes □ No

Do you snore? □ Yes □ No Do you use sleeping aids? □ Yes □ No *Explain:* _____

Roles / Relationship

Marital status: □ Single □ Married □ Divorced □ Gay/Lesbian □ Long Term Partnership □ Widow

Spouses name: _____

Child's Name	Age	Gender

Who is living in your Household? *Number* _____ *Names* _____

Their Employment/Occupation: _____

Resources for emotional support? *Check all that apply*

□ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: _____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your spouse/boyfriend/girlfriend				
With your children				
With your parents				

Readiness Assessment

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

Significantly improve your diet _____ □ 5 □ 4 □ 3 □ 2 □ 1
Take several nutritional supplements each day _____ □ 5 □ 4 □ 3 □ 2 □ 1
Start preparing your own meals _____ □ 5 □ 4 □ 3 □ 2 □ 1
Modify your lifestyle _____ □ 5 □ 4 □ 3 □ 2 □ 1
Practice a relaxation technique _____ □ 5 □ 4 □ 3 □ 2 □ 1
Engage in regular exercise _____ □ 5 □ 4 □ 3 □ 2 □ 1
Have periodic lab tests to assess your progress _____ □ 5 □ 4 □ 3 □ 2 □ 1
Get regular bodywork such as chiropractic or massage _____ □ 5 □ 4 □ 3 □ 2 □ 1
Setting regular appointments _____ □ 5 □ 4 □ 3 □ 2 □ 1
Read books or articles to learn about your health and solutions _____ □ 5 □ 4 □ 3 □ 2 □ 1
Be fully responsible for your own healing _____ □ 5 □ 4 □ 3 □ 2 □ 1

Comments: _____

_____

How confident are you of your ability to organize and follow through on the above health related activities?
Rate on a scale of: 5 (very confident) to 1 (not confident at all) □ 5 □ 4 □ 3 □ 2 □ 1 *If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?* _____

_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? *Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)* □ 5 □ 4 □ 3 □ 2 □ 1 *Comments:* _____

_____

_____

How much ongoing support and contact *(office visits)* from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* □ 5 □ 4 □ 3 □ 2 □ 1
Please list how often you would be willing to make appointments if needed _____
Comments: _____

_____

_____

4-Day Diet Diary Instructions

There is a 4-day diet diary at the end of this packet. It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 4 consecutive days including one weekend day. Please feel free to carry it with you as it is often easier to write down what you consume shortly after you consume it, rather than wait until the end of the day.

- **Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.**
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, or nonfat); toast – (whole wheat, white, buttered); chicken - (fried, baked, or breaded); coffee – (decaffeinated w/ sugar & ½ 'n' ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, **including water**, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits in this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

ASQ – Appraisal and Symptom Questionnaire – (Abbreviated)

Name: _____ *Date:* _____

The Health Appraisal and Symptom Questionnaire is designed to elucidate symptoms that help to identify the underlying causes of illness, as well as help track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is significant
3 = Frequently have it, effect is significant
4 = Frequently have it, effect is very significant

Digestive Tract
___Nausea or vomiting
___Diarrhea (loose stools or >3x/day)
___Constipation (not going everyday)
___Bloated feeling or abdominal swelling
___Belching or passing gas
___Heartburn of GERD
___Intestinal/stomach pain
___Reactions to foods
___Gallstones or pain after fatty meals
___Bad breath
___Blood or mucous in stool
___Other_____
Total _____

Ears
___Itchy ears
___Earaches, ear infections
___Drainage from ear
___Ringing in ears, hearing loss
Total _____

Emotions
___Mood swings
___Anxiety, irritability
___Anger or emotional outbursts
___Depression
Total _____

Energy/Activity
___Fatigue, sluggishness
___Apathy, lethargy
___ Hyperactivity
___Restlessness
___Restless legs
___General feeling of ill health
Total _____

Eyes
___Watery or itchy eyes
___Swollen, reddened or sticky eyelids
___Bags or dark circles under eyes
___Blurred or tunnel vision *(does not include near-or-far-sightedness)*
Total _____

Head
___Headaches
___Faintness
___Dizziness or vertigo
Total _____

Heart
___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest pain
Total _____

Joints/Muscles
___Pain or aches in joints
___Arthritis
___Stiffness or limitation of movement
___Pain or aches in muscles
___Feeling of weakness or tiredness
___Muscle cramping
Total _____

Lungs
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficulty breathing
___ Inability to take deep breaths
Total _____

Mind
___Poor memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___Stuttered speech
___Slurred speech
___Insomnia
___Learning disabilities
Total _____

Nose
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation
Total _____

Skin
___Acne
___Hives
___Hair loss/thinning
___Rash or reddened skin
___Excessive sweating
___Edema
___Dry or oily skin (circle which)
___Dry, cracked nails
___Body odor offensive or strong
Total _____

Weight
___Binge eating
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water retention
___Underweight
Total _____

Mouth/Throat
___Chronic coughing
___Gagging, frequent throat clearing
___Sore throat, hoarseness, loss of voice
___Swollen/discolored tongue, gums, lips
___Canker sores
___Sticky coating on tongue
___Dry, cracked lips
Total _____

Immune
___Frequent illness
___Teeth infection/bleeding
___Frequent or urgent urination
___Urinary tract infections
___Genital itch/discharge or STD outbreak
Total _____

Hormones
___Awake feeling un-refreshed/tired
___Craving salty/sweet foods (circle which)
___Low or High Libido (circle)
___Facial or unusual hair growth
___Flushing or hot flashes
___Painful/abnormal periods (females)
___Cold hand/feet
___Frequent thirst
___Dizziness when standing
*Total*_____

Grand Total _____

Diet Diary: *Name* _____ *Date:* _____

Day 1

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Diet Diary: *Name* _____ *Date:* _____

Day 2

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____
Stress/Mood/Emotions _____
Other Comments _____

Diet Diary: *Name* _____ *Date:* _____

Day 3

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____
Stress/Mood/Emotions _____
Other Comments _____

Diet Diary: *Name* _____ *Date:* _____

Day 4

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____
Stress/Mood/Emotions _____
Other Comments _____

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

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 Department of Personnel and Administration (DPA) of the State of Colorado (State), is committed to protecting the privacy of health information maintained by the group health plans sponsored by the State. This is your Health Information Privacy Notice from the State of Colorado's medical insurance plan (referred to as We or Us). This notice is solely for your information. You do not need to take any action. In this notice, the terms your "medical information" or your "health information" or your "Personal Health Information" (PHI) mean personal information that identifies you and that relates to your past, present, or future physical or mental health; the provisions of health care services to you; or the payment of health care services provided to you.

This notice provides you with information about the way in which We protect PHI that We have about you. The Health Insurance Portability and Accountability Act ("HIPAA") requires Us to: keep PHI about you private; provide you this notice of our legal duties and privacy notices with respect to your PHI; and follow the terms of the notice that are currently in effect.

The group health plans are administered by select State Employees and third-party administrators. For a more detailed explanation of the limited ways that State employees provide plan administration functions, please see the section below on Plan Sponsor.

This notice explains how we use your health information and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights. We are required to follow the terms of this notice until the notice is replaced. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide you with a copy of the new notice.

How We May Use or Disclose Your Health Information

We obtain PHI in the course of providing and/or administering health insurance benefits for you. In administering your benefits, We may use and/or disclose PHI about you and your dependents. The following are some examples, however, not every use or disclosure in a category will be listed.

Treatment We may use and disclose information when communicating with your Physicians to help them provide medical care to you. For example, we might suggest to your Physician a disease management or wellness program that could improve your health.

Payment We may use and disclose information about you so that the medical services you receive can be properly billed and paid. For example, we may need to give your insurance information to health care providers so they can bill us for treating you.

Operations We may use and disclose information about you for our business operations. For example, we may disclose information about you to consultants who provide legal, actuarial, or auditing services. We will not disclose your health information to outside groups unless they agree in writing to keep it protected.

Data Aggregation For example, We may combine PHI about many insured participants to make plan benefit decisions, and the appropriate premium rate to charge.

Research We may use or disclose information to conduct research as permitted by the HIPAA privacy rule.

To You About Dependents For example, We may use and disclose PHI about your dependents for any purpose identified herein. We may provide an explanation of benefits for you or any of your dependents to you.

To Business Associates For example, We may disclose PHI to administrators who are contracted with us who may use the PHI to administer health insurance benefits on our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits.

We may also use or disclose your health information for other health-related Benefits and services. For example, we may send you appointment reminders or information about programs that may be of interest to you, such as smoking cessation or weight loss.

There are also state and federal laws that may require or allow us to use or disclose your health information without your

authorization. The examples below are provided to describe generally the ways in which we may use or disclose your information.

- To state and federal regulatory agencies;
- For public health activities;
- To public health agencies if we believe there is a serious health or safety threat;
- With a health oversight agency for certain activities such as audits and examinations;
- To a court or administrative agency pursuant to a court order or search warrant;
- For law enforcement purposes;
- To a government authority regarding child abuse, neglect, or domestic violence;
- With a coroner or medical examiner, or with a funeral director;
- For procurement, banking or transplantation of organs, eyes, or tissue;
- For specialized government functions, such as military activities and national security;
- Due to the requirements of state worker compensation laws.

Plan Sponsor
Health information may be disclosed to or used by the State, as plan sponsor. For example, We may disclose to the State, information on whether you are participating in, enrolled in, or dis-enrolled from a group health plan. We may also disclose to the State, as plan sponsor, health information necessary to administer the group health plans. For example, the State may need your health information to review denied claims, to audit or monitor the business operations of the group health Plans, or to ensure that the group health Plans are operating effectively and efficiently. We will not use or disclose your health information to the State for any employment related functions. State employees who perform services to administer the group health plans are primarily, but not exclusively, in DPA's Division of Human Resources, Employee Benefits Unit. When State employees are conducting plan administration functions, they are acting as an administrator of the group health plans. Group health plan administrators will keep your health information separate from employment information and will not share it with anyone not involved in plan administration. For us to use or disclose your health information for any reason other than those identified in this section ("How We May Use or Disclose Your Health Information"), we must get written authorization from you. You may revoke the authorization at any time, but your revocation must also be in writing. The revocation will not affect any uses or disclosures consistent with the authorization made prior to receipt of the revocation by DPA's HIPAA Compliance Officer.

Your Rights Regarding PHI That We Maintain About You
You have various rights as a consumer under HIPAA concerning your PHI. You may exercise any of these rights by writing to Us in care of:

HIPAA Privacy Officer
State of Colorado
Colorado Department of Personnel and Administration
Division of Human Resources
1313 Sherman, First Floor Denver, Colorado 80203

The following are your rights with respect to your health information,
You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. All requests must be made in writing and state the specific restriction requested. We will try to honor your request, but we are not required to agree to a restriction.
You have the right to ask to receive confidential communications of information. For example, if you believe you would be harmed if we send information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by telephone) or to an alternative address. We will accommodate a reasonable request if the normal method or disclosure could endanger you and you state that in your request. Any such request must be made in writing.
You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A "designated record set" is a group of records that may include enrollment, payment, claims adjudication, and case or medical management records. However, you do not have the right to access certain types of information such as

psychotherapy notes and information compiled for legal proceedings. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

You have the right to ask us to amend the information we maintain about you in your designated record set (as defined above). Your request must be made in writing and you must provide a reason for the request. If we agree to your request, we will amend our records accordingly. We will also provide the amendment to any person that we know has received your health information from us, and to other persons identified by you. If we deny your request, we will notify you in writing of the reason for the denial. Reasons may include that the information was not created by us, is not part of the designated record set, is not information that is available for inspection, or that the information is accurate and complete.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request, but no earlier than July 1, 2005. We are not required to account for certain disclosures, such as disclosures made for purposes of treatment, payment, or health care operations, and disclosures made to you or authorized by you. Your request must be made in writing. Your first accounting in a 12-month period will be free. We may charge you a fee for additional accountings made within 12 months of the free accounting. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

You have a right to receive a copy of this notice upon request at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice for by submitting the request to: **HIPAA Privacy Officer**, State of Colorado, Department of Personnel and Administration, Division of Human Resources, 1313 Sherman Street, First Floor, Denver, Colorado 80203.

Additional Rights under HIPAA

- Most uses of and disclosures of PHI for marketing purposes and sales of PHI require your authorization.
- Most uses of and disclosures of psychotherapy notes require your authorization.
- You may be contacted to help raise funds and have the right to opt out of receiving such communications.
- You retain the right to obtain an electronic copy of the PHI maintained about you.
- You retain the right to be notified of a breach of your unsecured PHI.

Contacts

For further information, to receive a copy of this notice, or if you believe your privacy rights may have been violated and you want to file a complaint, please contact Department of Personnel and Administration's HIPAA Compliance Officer by U.S. mail or by e-mail, as follows:

U.S. Mail:
HIPAA Compliance Officer
State of Colorado
Department of Personnel and Administration
Division of Human Resources
1313 Sherman Street, First Floor
Denver, CO 80203

E-mail: dpahipaacompliance@state.co.us

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. No action will be taken against you for exercising your rights or for filing a complaint.

Changes To This Notice

We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to the insured/subscribers.