PATIENT INFORMATION

Patient's Name: _____ Gender: ____ D.O.B. ____ / ____ / _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Phone: (_____) _____ - _____

How did you hear about Airrosti? _____

Employer or School Name: _____

Emergency Contact: _____ Day Phone: (_____) _____ - _____

Financial Responsibility

In return for services rendered to me by the Airrosti Provider, I promise to pay in accordance with bills or invoices presented. If I participate in a health benefit plan, I acknowledge financial responsibility in accordance with the terms of the plan for any services rendered that my plan may exclude from payment for any reason.

ASSIGNMENT OF BENEFITS I understand that benefits quoted from my insurance carrier to Airrosti are only an estimate and not a guarantee of payment. I assign Airrosti all benefits payable to me under my insurance policies and health benefit plans. I shall be personally responsible for any unpaid balance to AIRROSTI Rehab Centers, LLC.

WORKERS' COMPENSATION Texas Department of Insurance – Division of Workers' Compensation (TDI-DWC) regulates fees and charges for medical aid, health care, and medicines. For those services provided which the TDI-DWC determines not to be work related, I understand that I am financially responsible. In the event of such determination, my insurance will be billed with benefits payable to AIRROSTI Rehab Centers, LLC.

MEDICARE I acknowledge that Airrosti is NOT a Medicare Provider and DOES NOT accept Medicare Benefits.

Statement of Understanding

At the time of your initial visit, an Airrosti Provider will explain and educate you on Airrosti's treatment services, including the use of manual therapy techniques and active care. After this explanation, if you do not want to receive Airrosti's services, then you are free to leave without obligation of payment. After the explanation, if you elect to receive Airrosti's services, then you will be treated, and you and/or your insurance company will be responsible for payment for all services. By signing below, you acknowledge that you understand the information described in this paragraph.

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

_____ _____

Signature of Patient (If Minor, Signature of Legal Guardian) Date

No Show/Cancellation Policy

Your Airrosti Treatment Team understands there may be circumstances which require you to cancel an appointment, but our requirement is that you notify our office **at least 24 hours in advance**. After one (1) "No Show" or two (2) "Less than 24 hours notice for cancellations", you will be limited to only Same Day Scheduling appointments. Same Day Scheduling means you can call in the morning to check for same day appointment availability.

To assist you in keeping your scheduled appointments, you will receive a reminder notification prior to your scheduled appointment.

Please acknowledge you have read and understand this policy by signing below.

_____

Signature of Patient or Guardian

AIRROSTI REHAB CENTERS, LLC

INFORMED CONSENT TO TREATMENT

Doctors of chiropractic and physical therapists who use manual therapy techniques such as the highly specific manual therapy, myofascial release, active rehab exercises, kinesio-taping, cryotherapy (ice), and occasional spinal adjustments should advise patients that there are or may be risks associated with such treatment. In particular you should note the following risks or complications:

a) **Manual Therapy, Myofascial Release:** local discomfort, skin reddening, superficial tissue bruising, release of emboli (rare), post treatment soreness, or increase in pain which can last up to 72 hours or notice that symptoms shift to different areas which is rarely a concern

b) **Active Rehab Exercises:** aggravation of present condition, blood pressure changes, increased heart rate

c) **Kinesio-Taping and cryotherapy (ice):** skin reactions including, but not limited to itching, allergic reactions, hyperpigmentation (discoloration), and blistering

d) **Sensitive Areas:** I recognize the nature of my injury may require the Airrosti provider(s) to perform treatment near or around sensitive area, i.e. chest, groin, buttocks, etc., and they will make every effort to safeguard my modesty and appropriately conceal the area

e) There have been reported cases of injury to a vertebral artery following **cervical spine adjustments**. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in death. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, strokes (CVA), dislocations, and sprains. I do not expect my Airrosti Provider to be able to anticipate and explain all risks and complications. Further, I wish to rely on their professional and clinical judgment during the course of my treatment which the Airrosti Provider feels are in my best interests at the time, based upon the facts then known.

Knowing that I have a condition requiring health care, I voluntary consent to treatment performed by the Airrosti Provider (including spinal manipulation). Though treatment is usually very beneficial and seldom causes any problems, I understand and have been informed of the potential risks. I have been informed about the methods used by Airrosti providers and have had the opportunity to ask questions and express concerns prior to treatment.

I have read and fully understand the above statements and I authorize Airrosti personnel to administer treatment as deemed necessary. I intend this consent to apply to all my present and future care.

Minor Consent: *If applicable, I have the legal right to select and authorize healthcare services for the minor child named above and I authorize an Airrosti provider to perform the treatment as outlined above to this minor.*

TO BE COMPLETED BY PATIENT:

Patient Signature: _____ ***Patient Name:*** _____
Signature of Patient/Legal Guardian **(*Please Print*)**

If Minor, Legal Guardian relationship to patient: _____

Date Signed: _____ *Patient Date of Birth:* _____

CURRENT PROBLEM & MEDICAL HISTORY

Patient's Name: _____ Referring Doctor: _____

Chief Complaint: Injury is on the: ☐ Right Side ☐ Left Side ☐ Both Sides

Please describe your injury and the purpose of your visit: _____

_____

Mechanism of Onset:

How did your injury happen?
- ☐ Gradual/Over Time
- ☐ Traumatic/All of a Sudden
- ☐ Don't Know
- ☐ Chronic

How long ago did it happen?
- ☐ Less than 14 days
- ☐ 2 weeks to 12 weeks
- ☐ 12 weeks to 1 year
- ☐ More than 1 year

For Work-Related Injuries:
Specific Injury Date: _____/_____/_____
Work Status: _____

Pain: Please rate your pain (0=no pain - 10=worst pain ever). Circle one: **0 1 2 3 4 5 6 7 8 9 10**

How much pain are you in today? ☐ None ☐ Very Little ☐ Moderate ☐ Significant ☐ Extreme Pain

When does your injury cause you pain? ☐ Constantly ☐ On and Off

What time of day does your injury cause you pain? ☐ Morning ☐ Afternoon ☐ Night

What best describes your pain?
- ☐ Ache ☐ Sharp
- ☐ Burning ☐ Shooting
- ☐ Dull ☐ Stabbing
- ☐ Numbness ☐ Throbbing
- ☐ Radiating ☐ Tingling

What best relieves your pain?
- ☐ Medication ☐ Rest
- ☐ Heat ☐ Activity
- ☐ Cold/Ice ☐ Nothing

What makes your pain worse?
- ☐ Standing ☐ Activity
- ☐ Sitting ☐ Other _____
- ☐ Rest

Sleep Disturbances: ☐ Difficulty Falling Asleep ☐ Difficulty Finding Comfortable Position ☐ Awakened by Pain

Prior Treatment for This Injury:

			Comments:
Have You Had Surgery for This Injury?	☐ Yes	☐ No	_____
Have You Seen a Specialist For This Injury?	☐ Yes	☐ No	_____
Were You Hospitalized For This Injury?	☐ Yes	☐ No	_____
Were You Advised to Have Surgery For This Injury?	☐ Yes	☐ No	_____
Any P.T. or Chiropractic Care For This Injury?	☐ Yes	☐ No	_____# of Visits

Medications: Are you taking any Medication for THIS Injury? ☐ Yes ☐ No

Please list all other Medications that you are taking below:
- ☐ Pain
- ☐ Steroids
- ☐ Diabetic
- ☐ Antidepressant
- ☐ Allergy
- ☐ Muscle Relaxers
- ☐ Blood Thinners
- ☐ Cholesterol
- ☐ Anti-inflammatory
- ☐ Cardiac
- ☐ Hypertension
- ☐ GI Tract

Please comment on any other medications not listed:
_____
_____
_____
_____
_____

Diagnostic Tests: Did you have any Diagnostic Imaging performed for THIS Injury? ☐ Yes ☐ No

- ☐ MRI
- ☐ Bone Scan
- ☐ EMG
- ☐ EEG
- ☐ CT Scan
- ☐ X-Ray
- ☐ Nerve Conduction
- ☐ Bone Density Scan

Please comment on any **positive** diagnostic test(s):
_____
_____
_____

Medical Conditions: Please indicate any of the following medical conditions you have experienced with THIS injury.
- ☐ Fracture
- ☐ Muscle Tear
- ☐ Tendon/Ligament Tear
- ☐ Obstructive Edema
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Warm Inflamed Skin
- ☐ Active Hemorrhage
- ☐ Localized Infection

PERTINENT MEDICAL HISTORY

Medical Condition

- ☐ Tuberculosis
- ☐ Kidney Disease
- ☐ Shortness of Breath
- ☐ Prostate
- ☐ Birth Defects
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Kidney Stone
- ☐ Hypoglycemia
- ☐ Hernia
- ☐ Rheumatic Fever
- ☐ Heart Attack
- ☐ Thyroid Disease
- ☐ Hepatitis
- ☐ Gall Bladder Disease
- ☐ Bronchitis
- ☐ Anemia
- ☐ Lung Disease
- ☐ Stroke
- ☐ AIDS/HIV+
- ☐ Bone or Joint Disease
- ☐ Gout
- ☐ Meningitis
- ☐ Sinus Infection
- ☐ Migraine Headaches
- ☐ Recurrent Headaches
- ☐ Multiple Sclerosis
- ☐ Irregular Heartbeat
- ☐ Pancreatitis
- ☐ Seriously Depressed
- ☐ Unexplained Weight Loss
- ☐ High Blood Pressure
- ☐ Venereal Disease
- ☐ Colon Infection
- ☐ Cancer
- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Trouble
- ☐ Diabetes

Allergies

- ☐ Seasonal _____
- ☐ Food _____
- ☐ Latex _____
- ☐ Other _____

Lifestyle Activities

Hobbies: _____

Sports: _____

Other Physical Activities: _____

FOR WOMEN ONLY

Please fill in the number of: ____ Pregnancies _____ Births _____Children

Please give any additional information on any difficult pregnancies, delivery complications, and/or menstrual problems:

_____

_____

Prior to Treatment

Is there anything else your provider should know about your condition prior to treatment? _____

_____

PATIENT SIGNATURE

_____ _____

Signature of Patient (If Minor, Signature of Legal Guardian) **Date**

Do not write below. For Airrosti Provider use only:

_____

_____

_____

_____

_____

_____

Release of Medical Information & Records

Patient's Name: _____ Date of Birth ____ / ____ / _____

By signing below I authorize Airrosti Rehab Centers, LLC to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, communicating with my referring physician, and any administrative operations related to treatment or payment as noted in Airrosti's Notice of Privacy Practices. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I understand that Airrosti will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I retain the right to revoke this consent by notifying the practice in writing at any time. In addition, I am authorizing Airrosti to communicate my personal health information to the following individual(s), organization, or employer as I have written below:

_____

_____

I have read and fully understand the above statements and I authorize trained and licensed personnel to administer treatment as deemed necessary.

_____ _____

Signature of Patient (If Minor, Signature of Legal Guardian) Date

ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I, _____, (patient's name) acknowledge that I have received, reviewed, understand and agree to the Joint Notice of Privacy Practices (the "Notice") of the Airrosti entities listed in Appendix A of the Notice (collectively referred to as the "AOHCA"). I acknowledge that this Notice describes the AOHCA's policies and procedures regarding the use and disclosure of my Protected Health Information created, received, transmitted, or maintained by the AOHCA.

In addition, I agree to authorize the AOHCA to communicate the Notice and my protected health information through the use of phone, voice mail, e-mail, text messages, and personal communication, i.e. birthday cards, thank you notes, etc., as well as including electronic communication for announcements, newsletters, or other similar purposes.

_____ _____

Date Signature of Patient (or Patient's Authorized Representative)

_____

Printed Name of Patient (or Patient's Authorized Representative)

_____

If Applicable, Relationship to, or Description of the Authority to Act for, the Patient

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FOR OFFICE USE ONLY IF THE PATIENT DOES NOT ACKNOWLEDGE THE NOTICE

The AOHCA has made a good-faith effort to obtain an acknowledgement of _____ (patient's name) receipt of our Notice. In spite of these efforts, the AOHCA has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling
- ☐ Other _____

In an effort to obtain the patient's acknowledgement, the AOHC has attempted to provide the patient with the Notice in the following manner (check all that apply):

☐ Personally ☐ Mail ☐ Website ☐ Other _____

_____ _____

Date Signature

_____

Printed Name of Airrosti Representative

_____

Name of Airrosti Affiliate

AIRROSTI ORGANIZED HEALTH CARE ARRANGEMENT
JOINT NOTICE OF PRIVACY PRACTICES
Version No.2
Effective Date June 3, 2013

THIS JOINT NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. Presentation of this Notice by the Airrosti Organized Health Care Arrangement

This Notice describes the privacy practices of the various Airrosti entities listed on **Appendix A** attached to this Notice. These Airrosti entities and other affiliated health care providers as well as their employees, volunteers, contractors, students, agents, and other members of their workforce are collectively referred to hereinafter as the "Airrosti Organized Health Care Arrangement" or "AOHCA". This Notice applies to services furnished to you by AOHCA.

AOHCA is comprised of affiliated entities that function as an organized health care arrangement in a clinically integrated care setting. These AOHCA entities need to share health information freely for purposes of treatment, payment or health care operations. They participate jointly in utilization review, quality assessment, improvement activities, and payment activities. These AOHCA entities and their practitioners are not jointly and/or severally responsible or liable for each other's actions, which include their health care services and compliance with privacy and security laws.

II. Privacy Obligations

AOHCA is required by law to maintain the privacy of your health information, referred to as "Protected Health Information" or "PHI," and to provide you with this Notice of legal duties and privacy practices with respect to your PHI. When AOHCA uses or discloses your PHI, AOHCA is required to abide by the terms of this Notice.

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which are described in Section IV below, your written authorization must be obtained in order to use and/or disclose your PHI. However, AOHCA does not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. In general, your PHI may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as described below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you -- for example, AOHCA may communicate with your other physicians in order for you to receive additional treatment from these physicians.
- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you -- for example, AOHCA may disclosure your PHI to obtain payment from your health plan or to coordinate payment with other payors, as well as to verify that your health plan will cover the cost for particular health care services. Likewise, AOHCA may disclose PHI to an authorized representative of your employer for administration of your health plan and payment purposes.
- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, your PHI may be used to review the competence and qualifications of AOHCA's health care professionals and to conduct business planning and development relating to AOHCA.

Your PHI also may be disclosed to your other health care providers, when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. In addition, your PHI may be shared with business associates, and their subcontractors, who provide certain services to support AOHCA's services and health care operations. The AOHCA's contracts with its business associates require the business associates, and their subcontractors, to protect and safeguard the PHI of AOHCA's patients.

B. Use or Disclosure for Additional Benefits. The AOHCA may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you provide to AOCHA an email address, we will include you in the distribution of our electronic newsletter. You will have the ability to "opt out" upon your initial receipt of this e-newsletter. .

C. Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be used or disclosed to family members, other relatives, close personal friends or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if (1) your agreement is obtained; (2) you are provided with the opportunity to object to the disclosure, and you do not object; or (3) it can be reasonably inferred that you do not object to the disclosure. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

D. Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to federal or state authorities authorized by law to receive such reports; (3) to report information about products or services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may be at risk of spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work related illnesses and injuries or workplace medical surveillance.

E. Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

F. Health Oversight Activities. Your PHI may be disclosed to a state or federal health oversight agency that oversees the health care system, or another agency that is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

G. Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process, so long as the court order or process complies with applicable federal and state law.

H. Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena, so long as the court order or subpoena complies with applicable federal and state law.

I. Decedents. Your PHI may be disclosed to a coroner, medical examiner or funeral director as authorized by law.

J. Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure and other requirements of state law are satisfied.

K. Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to your, a person's or the public's health or safety.

L. Specialized Government Functions. Your PHI may be used or disclosed to federal officials for lawful intelligence, counter-intelligence, and other national security activities. If you are a member of the armed forces or a foreign military authority, your PHI may be used or disclosed to the appropriate military authorities under certain circumstances.

M. Disaster Relief. Your PHI may be disclosed to the American Red Cross, or other agencies that provide similar services, in order to access any information necessary to perform its duties to provide biomedical services, disaster relief, disaster communication, or emergency leave verification services for military personnel.

N. Workers' Compensation. Your PHI may be disclosed as authorized by, and to comply with, state law relating to workers' compensation or other similar programs.

O. Disaster Relief. Your PHI may be disclosed to the American Red Cross, or other agencies that provide similar services, in order to access any information necessary to perform its duties to provide biomedical services, disaster relief, disaster communication, or emergency leave verification services for military personnel.

P. As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories.

Q. Appointment Reminders. We may use and disclose your PHI to contact you to remind you that you have an appointment for medical care with one or more of our providers.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III or as otherwise provided below, your PHI may be used or disclosed only when you provide your written authorization on an authorization form. For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company; or, in some instances, before your PHI can be disclosed in connection with litigation.

B. Marketing. Your authorization must be obtained for any use or disclosure of your PHI for marketing purposes, except if the communication: (1) is in the form of face-to-face communication made by AOHCA to you; (2) is in the form of a promotional gift of nominal value provided by AOHCA to you; (3) is made to describe AOHCA's health-related products or services (or payment for such products or services) that are provided by AOHCA, so long as AOHCA does not receive direct or indirect payment in exchange for the making of the communication; (4) is for treatment, including case management or care coordination, or to recommend alternative treatments. If AOHCA is selling your PHI or using or disclosing your PHI for marketing purposes and it involves payment to AOHCA, you must sign an authorization and the authorization must state that such payment is involved.

C. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI such as: (1) psychotherapy notes; (2) mental health and/or mental retardation information; (3) alcohol and drug abuse prevention, treatment, and referral information; (4) HIV/AIDS or other sexually transmitted disease testing, diagnosis or treatment; (5) child abuse and neglect information; (6) sexual assault information; (7) social security numbers; or (8) genetic information. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization must be obtained.

D. Reidentified Information. The AOHCA shall not reidentify or attempt to reidentify you as the subject of any PHI without obtaining your consent or authorization if required under state or federal law.

E. Research. When a research study involves your treatment, AOHCA may disclose your PHI to researchers after receiving your authorization.

F. Electronic Disclosures. AOHCA is providing you with notice that your PHI may be subject to electronic disclosure. AOHCA may not electronically disclose your PHI to any person without your authorization, which may be obtained in written or oral form if it is documented by AOHCA. However, such authorization is not required for an electronic disclosure of PHI if the disclosure is made: (1) to another health care provider, health plan or covered entity as defined under State law for the purpose of: (a) treatment; (b) payment; (c) health care operations; or (d) performing an insurance or health maintenance organization function; or (2) as otherwise authorized or required by state or federal law.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Privacy Officer. You may also file written complaints with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights

(the "Secretary"). Upon request, the Privacy Officer will provide you with the procedures for filing a complaint and correct address for the Secretary. The AOHCA will not retaliate against you, if you file a complaint with the Privacy Officer or the Secretary.

B. Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, AOHCA is not required to agree to a requested restriction; unless the request pertains to a disclosure of your PHI to a health plan for purposes of payment or health care operations (and is not otherwise required by law); and you, or any person on behalf of you (other than the health plan), has paid in full the health care provider for your health care services. If you wish to request additional restrictions, please obtain a request form from the Privacy Officer.

C. Right to Receive Confidential Communications. You may request that you receive your PHI by alternative means of communication or at alternative locations.

D. Right to Revoke Your Authorization. You may revoke your authorization, except to the extent that AOHCA has taken action in reliance upon it, by delivering a written revocation statement to the Privacy Officer identified below.

E. Right to Inspect and Obtain a Copy of Your Health Information. You may request access to, and copy, your medical record file and billing records maintained by AOHCA. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Privacy Officer and submit the completed form to the Privacy Officer. If you request copies, you will be charged in accordance with AOHCA's policies and procedures in compliance with federal and state law. You also will be charged for postage costs, if you request that the copies be mailed to you. If AOHCA is using an electronic health records system, then you are entitled to obtain your records in electronic form.

F. Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Privacy Officer and submit the completed form to the Privacy Officer.

G. Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request, provided such period does not exceed six years. If the disclosures of your PHI are in an electronic health record, then you may obtain an accounting of most disclosures of your PHI during any period of time over the last three years prior to such request. If you request an accounting more than once during a twelve (12) month period, you may be charged.

H. Right to Receive Notice of a Breach. The AOHCA is required to notify you of a breach of your unsecured PHI that is discovered by AOHCA.

I. Electronic Notice and Right to Receive Paper Copy of this Notice. By signing the acknowledgment to this Notice, you agree to receive this Notice via e-mail. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Duration and Changes to this Notice

The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that AOHCA maintains, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice may be posted, as applicable, in AOHCA's offices and/or on AOHCA's internet site. You also may obtain any new notice by contacting the Privacy Officer.

VII. Privacy Officer

You may contact the Privacy Officer at:

Brenda Reynolds, Privacy Officer
Airrosti Rehab Centers, LLC

Address: 911 Central Parkway North, Suite 300
San Antonio TX 78232

E-mail: privacy@airrosti.com
Phone Number: (800) 404-6050
Fax Number: (866) 298-4032

Appendix A

List of Entities Comprising the Airrosti Organized Health Care Arrangement Covered Under this Joint Notice of Privacy Practices

Airrosti Buckeye, Inc.

Airrosti Great Lakes, Ltd.

Airrosti Peak, PC

Airrosti Potomac, LLC,

Airrosti Rainier, PC

Airrosti Rehab Centers, LLC

Airrosti Center, Inc.

Airrostifarian, LLC