CIGNA ONSITE HEALTH PATIENT INFORMATION FORM

Check one of the following:
Attach copy of front and back of Insurance card

☐ All Cigna Insurance ☐ Other Insurance (Any Non-Cigna) ☐ FFS/Self Pay

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SEX ☐ M ☐ F

STREET ADDRESS	CITY	STATE	ZIP CODE	PATIENT PHONE

RESPONSIBLE PARTY	RELATIONSHIP TO RESPONSIBLE PARTY	PATIENT E-MAIL ADDRESS

RESPONSIBLE PARTY STREET ADDRESS	CITY	STATE	ZIP CODE	RESPONSIBLE PARTY PHONE

LANGUAGE	ETHNICITY	RACE

INSURANCE COVERAGE/OWNER OF INSURANCE POLICY

LAST NAME	FIRST	MI	DATE OF BIRTH	RELATIONSHIP TO PATIENT

STREET ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER	EMPLOYER ADDRESS *(STREET, CITY, STATE, ZIP CODE)*

WORK PHONE	HOME PHONE	INSURANCE CARRIER

INSURANCE CO. ADDRESS	INSURANCE CO. PHONE	POLICY / ID #	GROUP #

Is the patient covered under any other health coverage? ☐ **Yes** ☐ **No** **If Yes, complete Additional Healthcare Insurance section.**

ADDITIONAL HEALTHCARE INSURANCE (Medicare Part B – FFS, Supplemental, All Other Insurance)

LAST NAME	FIRST	MI	DATE OF BIRTH	RELATIONSHIP TO PATIENT

STREET ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER	EMPLOYER ADDRESS *(STREET, CITY, STATE, ZIP CODE)*

WORK PHONE	HOME PHONE	INSURANCE CARRIER

INSURANCE CO. ADDRESS	INSURANCE CO. PHONE	POLICY / ID #	GROUP #

IN CASE OF EMERGENCY CONTACT

LAST NAME	FIRST	MI	RELATIONSHIP	HOME PHONE

Your signature below indicates:

1. (If you have insurance) You authorize Cigna Onsite Health (COH) to release medical or other information as requested by your insurance company to have your medical claims paid.
2. (If you have insurance) You authorize direct payment of medical benefits by your insurance company to COH for any services furnished to you and otherwise payable to you.
3. Your agreement to pay any and all final balance due to COH for services you receive which are your responsibility and/or are denied by your insurance company.

Patient/Parent or Legal Guardian Signature ______________________________ Date ______________

Cigna Onsite Health Adult Medical History

Name ______________________	Today's Date ______________
Gender ☐ Male ☐ Female	Date of Birth ______________

Marital Status ☐ Single ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Pharmacy (name, address, phone):

Primary Care Provider (name, address, phone):

Do you have a primary care giver? ☐ No, I take care of myself. ☐ Yes, I have a primary care giver.

Primary Care Giver Name, if applicable ______________________ Phone: ______________________	Primary Care Giver Relationship ☐ Father ☐ Mother ☐ Spouse ☐ Friend ☐ Significant Other ☐ Family Member ☐ Adult Child ☐ Other ______________

List any Specialists You See on a Regular Basis

Name	Address / Phone

Screening	Date of Screening	Screening	Date of Screening
Pap Smear		Bone Density	
Mammogram		Cholesterol	
Colonoscopy		Glucose	

	Have you ever been diagnosed with:	This is a current problem.	
☐	Allergies (type):	☐ Yes	☐ No
☐	ADD / ADHD	☐ Yes	☐ No
☐	Alcohol or Drug Problem	☐ Yes	☐ No
☐	Anemia	☐ Yes	☐ No
☐	Anxiety	☐ Yes	☐ No
☐	Arthritis (type):	☐ Yes	☐ No
☐	Asthma	☐ Yes	☐ No
☐	Blood Clot	☐ Yes	☐ No
☐	Cancer (type):	☐ Yes	☐ No
☐	Chronic Pain (Pain Management)	☐ Yes	☐ No

915727 12/2017

Have you ever been diagnosed with:		This is a current problem.	
☐	COPD	☐ Yes	☐ No
☐	Depression	☐ Yes	☐ No
☐	Diabetes (type):	☐ Yes	☐ No
☐	Hepatitis (type):	☐ Yes	☐ No
☐	High Blood Pressure	☐ Yes	☐ No
☐	High Cholesterol	☐ Yes	☐ No
☐	Heart Disease	☐ Yes	☐ No
☐	Inflammatory Bowel (Chrons, Colitis)	☐ Yes	☐ No
☐	Kidney Disease	☐ Yes	☐ No
☐	Liver Disease	☐ Yes	☐ No
☐	Migraines	☐ Yes	☐ No
☐	Overweight / Obesity	☐ Yes	☐ No
☐	Rash / Skin Disease (type):	☐ Yes	☐ No
☐	Reflux (heartburn)	☐ Yes	☐ No
☐	Seizures	☐ Yes	☐ No
☐	Sleep Apnea	☐ Yes	☐ No
☐	Thyroid Disease (type):	☐ Yes	☐ No
☐	Ulcer	☐ Yes	☐ No
☐	Other (list):	☐ Yes	☐ No

List Surgeries and Hospitalizations ☐ I have not had any surgeries or hospitalizations.

Surgery / Hospitalization	Date	Surgery / Hospitalization	Date
Removal of Tonsils		**Woman:** D&C	
Removal of Appendix		**Woman:** Hysterectomy	
Removal of Gallbladder		**Woman:** Breast Biopsy	
Removal of Hemorrhoids		**Woman:** Mastectomy	
Removal of Colon (partial)			

Family History:	Father	Mother	Sister	Brother
☐ Family History Unknown				
Anemia	☐	☐	☐	☐
Alcohol / Drug Problem	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer (type):	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes (type):	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Disease (type):	☐	☐	☐	☐
Other (List):	☐	☐	☐	☐

		Frequency	
Exercise	☐ Yes ☐ No	Type of Exercise	Days per week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
Alcohol	☐ Yes ☐ No	Drinks per week:	
Tobacco Use	☐ Yes ☐ No	☐ Cigarette ☐ Cigar ☐ Pipe ☐ E-Cigarette ☐ Chew/Snuff	Per Day Usage: ☐ 1-10 ☐ 11-20 ☐ 21-40 ☐ 40+
Drug Use	☐ Yes ☐ No	List all recreational / illicit / chronic opioid drug use:	

Allergies:

☐ I have no **food** allergies. ☐ I have no **medication** allergies. ☐ I have no **environmental** allergies.

Food	Reaction				
☐ Peanuts	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Tree Nuts	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Gluten	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Shellfish	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Fish	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Soy	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Eggs	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Other:	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Other:	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting

Medication	Reaction				
☐ Penicillin	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Sulfa	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Aspirin	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Ibuprofen	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Other:	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Other:	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting

Environment	Reaction				
☐ Grass	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Mold	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Pollen	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Bees	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Dust Mites	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Cats	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Dogs	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Other:	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting
☐ Other:	☐ Anaphylaxis	☐ Hives	☐ Abdominal Pain	☐ Itching	☐ Vomiting

List All Your Medications.
Include over-the-counter medications and "as needed" medications such as epi pens and inhalers.

Medication Name	Dose and Directions

Immunizations	
When was your last Tetanus shot?	Date:

NOTE: Please bring a copy of your immunization records for all of the following:

MMR	Hepatitis A	Influenza
Varicella	Hepatitis B	Meningitis
Polio	Tdap / TD	
HPV	Pneumococcal	

Authorization for the Release of Information

I. INFORMATION ABOUT USE OR DISCLOSURE

By signing this authorization, I authorize the use or disclosure of my protected health information ("PHI") as described below.

Patient Name:			Date of Birth:
Address:	City	State	Zip Code
Phone Number *(provide one)*: Home: Cell:			

If covered under a medical plan, please provide the following information:

Member/Participant Identification Card ("ID Card") Number:	Policy, Group or Account Number on ID Card:
Subscriber Name:	Subscriber Employer:
Subscriber's Relationship to Patient:	

I authorize Cigna Onsite Health, LLC ("COH"), Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company and their affiliates and agents (collectively referred to as "Cigna") to use and disclose my PHI for the purposes identified below.

I authorize COH, Cigna, my medical plan or its vendor(s), to receive my PHI for the purposes identified below.

Purpose of the use and disclosure:
COH, my medical plan and Cigna, an administrator of my medical plan will use and disclose PHI to provide health management or to administer an incentive program. This authorization will allow reporting of health data at the aggregate level only (de-identified data which does not include my name or other identifiable information) to my employer or health plan for the purpose of creating health program improvements, and identifiable data to my employer only for the purpose of incentive programs. I also authorize COH, my medical plan and Cigna to use and disclose PHI in the form of my name and fact/date of visit to the clinic as requested by my employer for payment, collection and payroll deduction purposes (as applicable).

For purposes of this Authorization, PHI includes but is not limited to the following:
Pharmacy and prescription drug information, laboratory test results, disease and health management information, visit notes, results of analytical models, health advocacy program participation, eligibility benefits information, biometric data, vaccinations, genetic testing information, demographic and claims information, Point of Service information such as location information, provider name, etc., alcohol or drug abuses treatment program information, psychotherapy notes, communicable disease-related and HIV-related information.

II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization by sending a written request to Cigna Onsite Health, LLC, 25600 N. Norterra Drive, Phoenix, Arizona 85085-8200. A revocation form is available from the onsite health center staff. The revocation will not have any effect on actions that COH or Cigna took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care, enrolling in a health plan or eligibility for benefits.
- A copy of this authorization and notation concerning the persons or agencies to whom disclosures are made shall be included with original health records.
- This authorization expires twelve (12) months from the date of signature.

III. SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

Signature of Patient:	Date:
Signature of Personal Representative or Parent/Guardian:	Date:
Printed Name of patient's personal representative:	
Relationship if the person signing is other than Patient whose information is to be used and disclosed:	

Please note: If the State in which services are provided permits minors to obtain care without parent/guardian's consent, please obtain the minor's signature to consent to authorize information disclosure of those services.

The information used or disclosed pursuant to the authorization may be re-disclosed by the recipient and, upon re-disclosure, no longer be protected by federal privacy laws.

We recommend that you keep a copy of your completed form for your records. Cigna and Cigna Onsite Health, LLC will retain a copy which will be made available upon your request.

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, and not by Cigna Corporation.

Cigna Onsite Health General Consent for Medical Treatment

Patient Name: ______________________________ Date of Birth: ______________

Member ID: ______________

I, the patient named above (or his or her representative), hereby voluntarily consent to care encompassing routine non-invasive medical care, tests, procedures, drugs and other services and supplies under the general and specific instruction of my clinician, assistant, designees or consultants, as may be necessary in the judgment of my clinician. I understand that I am authorizing "routine" services only and not complex diagnosis or therapeutic procedures. Except for an emergency or in extraordinary circumstances, I understand that additional consents will be obtained by the clinician if more invasive services are to be performed.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of any examination or treatment in this clinic. I understand that my medical records may be maintained in an electronic health record (EHR) and authorize to my records by persons involved in my care.

I understand and acknowledge that the COH clinic does not participate in the Medicare program or state Medicaid programs and that the diagnostic, care and treatment services provided by us will not be billed to Medicare or state Medicaid programs for reimbursement.

RIGHT TO REVOKE

My consent shall remain in effect until revoked in writing. I understand that I have the right to revoke this General Consent prior to treatment by providing written notice to the COH clinic where I am receiving treatment. It is understood that treatment will be denied if this General Consent for Treatment is not signed or revoked.

______________________________ ______________

Signature of Patient or Legally Authorized Representative Date

Mobile Phone Number: ______________ Alternate Phone Number: ______________

______________ ______________________________

Relationship to Patient Patient unable to sign due to

______________________________ ______________ ______________

Witness Date Time

Acknowledgement of Privacy Practices and Non-Discrimination Services

Patient Name: ______________________ Date of Birth: ____________

Member ID: ____________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the Cigna Onsite Health's (COH) Notice of Privacy Practices. I understand that COH reserves the right to change the terms of its Notice provisions and that I can obtain a copy upon request.

________ Patient to initial if refusing acknowledgement

Signature of Patient or Legally Authorized Representative ______________________ Date ____________

Relationship to Patient ____________ Patient unable to sign due to ______________________

Witness ______________________ Date ____________ Time ____________

NOTICE OF NON-DISCRIMINATION AND LANGUAGE SERVICES ASSISTANCE

I acknowledge that I have received a copy of the Non-Discrimination and Language Assistance Services Notice pursuant to the Patient Portability and Affordable Care Act, Section 1557, 45 CFR Part 92.

________ Patient to initial if refusing acknowledgement

Signature of Patient or Legally Authorized Representative ______________________ Date ____________

Relationship to Patient ____________ Patient unable to sign due to ______________________

Witness ______________________ Date ____________ Time ____________

874373 03/2017

Si desea recibir esta Aviso Sobre Practicas de Privacidad en español, por favor solicitela en nuestra Recepción.

Notice of Privacy Practices
Cigna Onsite Health

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.

Our Privacy Commitment

Thank you for giving us the opportunity to serve you. In the normal course of doing business – providing medical care to you – Cigna Onsite Health® ("COH") creates records about you and the treatment and services we provide to you. The information we collect is called Protected Health Information or ("PHI"). We take our obligation to keep your PHI secure and confidential very seriously.

We are required by federal and state law to protect the privacy of your PHI and to provide you with this Notice about how we safeguard and use it and to notify you following a breach of your unsecured PHI.

When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice. This Notice applies to all electronic or paper records we create, obtain, and/or maintain that contain your PHI, including clinical notes, lab results, X-rays, optometry and pharmacy information (medication history).

How We Protect Your Privacy

We understand the importance of protecting your PHI. We restrict access to your PHI to authorized workforce members who need that information for your treatment, for payment purposes and/or for health care operations. We maintain technical, physical and administrative safeguards to ensure the privacy of your PHI.

To protect your privacy, only authorized and trained workforce members are given access to our paper and electronic records and to non-public areas where this information is stored.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures including how paper and electronic records are labeled, stored, filed and accessed.
- Technical, physical and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow the policies and procedures, and educates our organization on this important topic.

How We Use and Disclose Your PHI

Uses of PHI without your authorization

We may disclose your PHI without your written authorization if necessary while providing your health benefits. We may disclose your PHI for the following purposes:

- **Treatment:**
  - To share with nurses, doctors, pharmacists, optometrists, health educators and other health care professionals so they can determine your plan of care.
  - To help you obtain services and treatment you may need – for example, to order lab tests and use the results.
  - To coordinate your health care and related services with a different health care facility or professional
- **Payment:**
  - To make coverage determinations.
  - To submit claims to your health plan or health insurer.
  - To coordinate benefits with other coverage you may have.
- **Health care operations:**
  - To provide customer service.
  - To support and/or improve the programs or services we offer you.
  - To assist you in managing your health – for example, to provide you with an appointment reminder or information about treatment alternatives to which you may be entitled.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**
  - If you are present or otherwise available to direct us to do so, we may disclose your PHI to others – for example, a family member, a close friend, or your caregiver.

Together, all the way.®

Cigna®

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- If you are in an emergency situation, are not present, or are incapacitated, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interests. If we do disclose your PHI in a situation where you are unavailable, we would disclose only information that is directly relevant to the person's involvement with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition or your death.
- We may disclose your child's PHI to your child's other parent.

If you do not want us to disclose your PHI or your child's PHI to others, please tell your COH health care professional.

- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
  - Companies that perform certain services we've requested. For example, we may engage vendors to help us to provide information and guidance to participants with chronic conditions like diabetes and asthma.
  - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.

- **Disclosures to your employer as sponsor of your health plan or health insurance policy.** We may disclose your PHI to your employer or to a company acting on your employer's behalf, so that entity can monitor, audit and otherwise administer the employee health plan or health insurance policy in which you participate. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your employer's health plan or policy documents for information on whether your employer receives PHI and, if so, the identity of the employees who are authorized to receive your PHI.
- **Communications.** We may disclose your PHI to:
  - Encourage you to purchase or use a product or service that is not part of the health care services and benefits we provide when we meet with you in person, as permitted by law.
  - Provide you with a promotional gift of nominal value. Except as permitted by law, we will not use your PHI for marketing purposes without your prior written authorization.
- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.
- **Public health activities.** We may disclose your PHI to:
  - Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
  - Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
  - Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity.
  - Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this Notice.
- **Health oversight activities**. We may disclose your PHI to:
  - A government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid.
  - Other regulatory programs that need health information to determine compliance. This disclosure may include granting an agency surveyor access to your electronic health record.
- **Research.** We may disclose your PHI for research purposes, but only according to and as allowed by law.
- **Compliance with the law**. We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government such as the U.S. military or the U.S. Department of State as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.

Uses of PHI that require your authorization

Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we would need your authorization:

- To supply PHI to your employer.
- To use your PHI for marketing communications and when we receive direct or indirect payment from a third party for making such communications.
- For any sale involving your PHI, as required by law.

Uses and disclosures of certain PHI deemed "Highly Confidential." For certain kinds of PHI, federal and state law may require enhanced privacy protection. These would include PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment and referral.
- Additional diseases and/or treatments specifically defined by state law (e.g. HIV/AIDS, venereal disease, communicable disease, genetic testing, etc.).

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law. Any other uses and disclosures not described in this Notice will only be made with your prior written authorization.

Cancellation. You may cancel ("revoke") a written authorization you gave us before. The cancellation, submitted to us in writing, will apply to future uses and disclosures of your PHI. It will not impact disclosures made previously, while your authorization was in effect.

Your Individual Rights

You have the following rights regarding the PHI that COH creates, obtains, and/or maintains about you.

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment and health care operations, as explained in this Notice. We are not required to agree to the restrictions, but we will consider them carefully. If we do agree to the restrictions, we will abide by them.

  At certain COH locations, you may be allowed to restrict ("to not disclose") information to your health plan or health insurer about a COH-provided visit, service or prescription for which you pay. If this option is available to you, you may exercise this right by paying in full, out-of-pocket, at the time of service. If you do so, we will not submit any claim or otherwise communicate with your health plan or health insurer about the visit, service or prescription.
- **Right to receive confidential communications.** You may ask to receive COH communications containing PHI by alternative means or at alternative locations. We will accommodate reasonable requests whenever feasible.
- **Right to inspect and copy your PHI.** You may ask in advance to review or receive a copy of your PHI that is included in certain paper or electronic records we maintain. Under limited circumstances, we may deny you access to a portion of your records.

  You may request that we disclose or send a copy of your PHI to a Health Information Exchange (HIE).
- **Right to amend your records.** You have the right to ask us to correct your PHI contained in our electronic or paper records if you believe it is inaccurate. If we determine that the PHI is inaccurate, we will correct it if permitted by law. If a different health care facility or professional created the information that you want to change, you should ask them to amend the information.
- **Right to receive an accounting of disclosures.** Upon your request, we will provide a list of the disclosures we have made of your PHI for a specified time period. However, the list will exclude:
  - Disclosures you have authorized.
  - Disclosures made earlier than six years before the date of your request (in the case of disclosures made from an electronic health record, this period may be limited to three years before the date of your request).
  - Disclosures made for treatment, payment, and health care operations purposes, except when required by law.
  - Certain other disclosures that are excepted by law.

If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for each accounting report after the first one.

- **Right to name a personal representative**. You may name another person to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the health care professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make health care decisions for you.
- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have already received one, as described in the Notice Availability and Duration section found later in this Notice.

Actions You May Take

Contact COH. If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us at the following address or telephone number:

Privacy Officer
Cigna Onsite Health
25500 N. Norterra Dr.
Phoenix, AZ 85085
Telephone Number: 1.800.591.9409

For certain types of requests, you must complete and mail to us the applicable form, which is available at our health care and event facilities.

Contact a government agency. If you believe we may have violated your privacy rights, you may also file a written complaint with the Secretary (the "Secretary") of the U.S. Department of Health and Human Services ("HHS").

Your complaint can be sent by email, fax, or mail to the HHS' Office for Civil Rights ("OCR"). For more information, go to the OCR website, **http://www.hhs.gov/ocr/privacy/hipaa/complaints**. We will provide you with the contact information for the OCR Regional Manager in your area, if you request it from our Privacy Office.

We will not take any action against you if you exercise your right to file a complaint, either with us or with the Secretary.

Notice Availability and Duration

Notice availability. A copy of this Notice is available at all of our health care and event facilities and is posted at the clinics and health coach offices, as applicable, in a prominent location at all times.

Right to change terms of this Notice. We may change the terms of this Notice at any time, and we may, at our discretion, make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will give you the new Notice as required when you receive treatment at one of our COH health care facilities or health coach offices or participate in a COH event, as applicable. In addition, we will post any new Notice at each of our COH health centers or health coach offices in a prominent location and you can request a copy at a clinic.

Effective date. This Notice is effective as of April 14, 2003, and updated as of September 23, 2013.

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Discrimination is Against the Law

Cigna and its affiliates, including Cigna Onsite Health, LLC ("Cigna") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact your Cigna Onsite Health Center and ask a representative for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-244-6224 (TTY: Dial 711).

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-244-6224 (TTY: 711）한국어

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-244-6224 (TTY:711) 번으로 전화해 주십시오.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-800-244-6224 (телетайп: 711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llameal 1-800-244-6224 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-244-6224 (TTY: 711).

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-244-6224 (رقم هاتف الصم والبكم: 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-244-6224 (ATS: 711).

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-244-6224 (TTY: 711).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-244-6224 (TTY: 711).

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-244-6224 (TTY: 711）まで、お電話にてご連絡ください。

فارسی (Farsi) (Persian)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-244-6224 (TTY: 711) تماس بگیرید.

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-244-6224 (TTY: 711).

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-244-6224 (TTY: 711).

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-244-6224 (TTY (հեռատիպ)՝ 711):

हिंदी (Hindi)
ચુના: જો તમે જરાતી બોલતા હો, તો િન: લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-800-244-6224 (TTY: 711).