145 ORTHOPAEDIC ASSOCIATES OF SOUTHERN CALIFORNIA

**Richard Lin, DO | Jaron Anderson, MD | Mark Cubberly,MD|**
**Kelvin Kim, MD | Ryan Stancil, MD | Martina Randall, DPM**
14642 Newport Ave #105 Tustin, CA 92780
710 N. Euclid Street #202 Anaheim, CA 92801
11180 Warner Ave #161 Fountain Valley, CA 92708
420 E.3rd Street #910 Los Angeles,CA 90013
**Phone: 949-688-0958| Fax: 949-688-0960**

## PATIENT INFORMATION

**Nombre :**_____**Fecha de Nacimiento**: _____
Apellido, Primer nombre

**Sex**: ☐ M ☐ F **SSN:** _____ **Estado Civil**: ☐ Casado ☐ Soltero ☐ Viudo ☐ Divorciado

**Domicilio:**_____**APT#:**_____
**Ciudad:**_____**State:**_____**Codigo Postal**: _____
**Primario Phone #:**_____**Secundario Phone #:** _____

**Correo Electronico**: _____

**Contacto de Emergencia:**_____**Relacion:** _____
**Numero De Telefono:** _____

**Ocupación**:_____**Empleador**: _____

**Familia de Familia:**_____**Telefono:** _____

**Farmacaia**:_____**Telefono**: _____

## HISTORIA MEDICO

**Razón de Consulta:** _____

**Medico Historia: Por favor marque todo lo que corresponda**

| | | | |
|---|---|---|---|
| | **Ninguno** | | **Alta Presion** |
| | **Heat Failure** | | **Diabetes** |
| | **Convulsion** | | **EPOC** |
| | **GI/GU** | | **Discapacidad Fisica** |
| | **Protesico Dispsotivo** | | **Enfermedad del Corazon** |
| | **Accidente Cerebrovascular** | | **Renal** |
| | **Cancer** | | **Problemas Psicologicos** |
| | **GERD** | | **Otro:** |

**Medicamento/ Alergias**

**Informe a la oficina si necesita espacio adicional para la lista de medicamentos:**

| Medicamento | Dosis/amount | Que Frecuencia |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please list allergies and reactions to any medication you have had in the past including food allergies.**

| Alergias a Medicamento | Reaccion |
|---|---|
| | |
| | |
| | |
| | |
| | |

1. Eres un roncador habitual y Ruidoso que molesta a tu companero? ☐ Si ☐ No
2. Te sientes cansada y atontada al despertar? ☐ Si ☐ No
3. Expermenta somnolencia y fatiga durante las horas de vigilia? ☐ Si ☐ No
4. Se ha observado que se ahoga/contiene a la respiracion durante el sueno? ☐ Si ☐ No
5. Esta tomadno o ha tomado alguna vez medicamentos con esteroides? ☐ Si ☐ No
6. Usa/fuma alguna sustancia recreative o que alter eel estado de animo? ☐ Si ☐ No
7. Ha Tendio fiebre, dolor de garganta o algun resfriado el la ultima semana? ☐ Si ☐ No

   Describa Brevemente: _____
8. Tiene dientes sueltos, dentaduras postiza, placas parciasles o coronas? ☐ Si ☐ No
9. ¿Ha fumado cigarrillos alguna vez? ☐ Si ☐ No

   En caso afirmativo, ¿cuántos paquetes al día?

   Por Cuanto Tiempo?_____ si dejaste, cuando dejaste? _____
10. Tomas bebidas alcohólicas?? ☐ Si ☐ No

**Nombre** : _____

_____ _____

Firma el Paciento (o Padre / Guardián legal) Fecha

**CUESTIONARIO DEL ANESTESIOLOGO**

**POR FAVOR LEA LO SIGUIENTE Y MARQUE TODO LO QUE CORRESPONDA A USTED. LA INFORMACIÓN OBTENIDA AYUDARÁ GRANDEMENTE A SU ANESTESIOLOGO A PLANIFICAR EL ANESTÉSICO MÁS SEGURO Y AGRADABLE PARA UTILIZAR SI LA RESPUESTA A CUALQUIERA DE ESTAS PREGUNTAS, POR FAVOR MARQUE NINGUNA**

| | **Lung Problems NONE ☐** | | **Heart Problems NONE ☐** | | **Bleeding Problems NONE ☐** | | | **Other NONE ☐** |
|---|---|---|---|---|---|---|---|---|
| | Bronquitis | | Ataque de Corazon | | Enfremedad Cerebral/Strokes | | | Problemes de Rinon |
| | Enfisema | | Soplo Cardicao | | Epilepsy/ Seizures | | | Problemes de Higado |
| | Asma | | Dolor de Pecho/Angina | | Nervous system problems | | | Hepatitis |
| | Wheezing | | Problemes de corazon | | Problemes de Tiroides | | | |
| | | | Palpitaciones/ Arritmia | | Diabetes | | | |
| | | | Alta Presion | | Enfermedad Muscular | | | |
| | | | Orta Problems de corazon | | Cancer | | | |
| | | | | | Apnea del Sueno | | | |

## Por fovar Enumere cualquier operación/cirugía/anestesia previa (incluida la anestesia en los consultorios dentales):

| Operacion | Fecha | Tipode Anestesia | Problemas (si los hay) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Enumere cualquier otra HOSPITALIZACIÓN NO incluida anteriormente.

1. _____
2. _____
3. _____

Algún pariente consanguíneo ha tenido alguna vez dificultad o problema con los anestésicos? (Hipertermia maligna )

☐ Si ☐ No En caso afirmativo, describa brevemente: _____

_____

_____

Nombre: _____ Fecha de Naciemiento : _____

## ASIGNACIÓN DE BENEFICIOS

Yo/nosotros por este medio consiento/autorizamos la realización de todos los tratamientos, cirugías y servicios médicos por parte del personal de Orthopaedic Associates of Southern California que consideren conveniente. Por la presente certifico que a mi leal saber y entender, todas las declaraciones contenidas en este documento son verdaderas. También autorizo a Orthopaedic Associates of Southern California a divulgar la información solicitada por la compañía de seguros y/o su representante. Por la presente acepto ceder todos los beneficios pagaderos por mi compañía de seguros a mi proveedor, Orthopaedic Associates of Southern California

_____I fully understand the agreement and consent will continue until cancelled by me in writing.

_____I authorize Orthopaedic Associates of Southern California to render necessary medical or surgical treatment to the above- named minor of whom I am the parent or legal guardian.

## ACUERDO FINANCIERO

Entiendo que soy directamente responsable de todos los cargos incurridos por el servicio médico para mí y mis dependientes, independientemente de la cobertura del seguro, excluyendo solo los servicios cubiertos autorizados provistos bajo un contrato HMO prepago válido. Por la presente acepto pagar la tasa de interés del 10% anual por todos los cargos pendientes incurridos por servicios médicos para mí y mis dependientes. Además, acepto pagar los gastos legales, incluidos los costos judiciales y los honorarios razonables del abogado, los gastos de la agencia de cobranza y todos los gastos incurridos para cobrar una cantidad que pueda deber según lo permitido por las leyes estatales y federales. Debido a que mi proveedor está facturando a mi seguro como una cortesía y por esta razón, puedo incurrir en una deuda con mi proveedor, por la presente autorizo la verificación de mi empleo en caso de que incurra en una deuda con mi proveedor..

| | | |
|---|---|---|
| Firma el Paciento /Guarantor | Nombre | Fecha |
| Frima de Garante (si el pacente es menor) | Nombre | Fecha |

**Tabla de tarifas de cancelación**

Las citas perdidas sin notificación previa o tardía se traducen en ingresos perdidos para cualquier proveedor. Las citas perdidas con frecuencia dan como resultado una pérdida financiera significativa para cualquier proveedor. Orthopaedic Associates of Southern California se reserva el derecho de cancelar los servicios médicos y/o el derecho de cobrar una tarifa por cualquier visita programada a pacientes que:

1. Cancelado con menos de 24 horas de anticipación.
2. Faltar a la cita sin llamar para cancelar (no presentarse).
3. Los pacientes que lleguen 15 minutos tarde o más tendrán que reprogramar y se considerará que no se presentaron.

**Otras tarifas de oficina**

**se debe pagar un cargo de $25 por formulario en el momento de la recogida. Al firmar a continuación, doy fe de que he leído y entendido el acuerdo y la política anterior.**

| | |
|---|---|
| Nombre de Paciente/ Firma del garante | Fecha |

## Consentimiento del paciente para el uso y divulgación de información de

Por la presente doy mi consentimiento para que Orthopaedic Associates of Southern California use y divulgue información de salud protegida sobre mí para llevar a cabo operaciones de tratamiento, pago y atención médica. El Aviso de prácticas de privacidad proporcionado por Orthopaedic Associates of Southern California describe dichos usos y divulgaciones de manera más completa. Tengo derecho a revisar el Aviso de prácticas de privacidad antes de firmar este consentimiento. Orthopaedic Associates of Southern California se reserva el derecho de revisar su Aviso de prácticas de privacidad en cualquier momento. Se puede obtener un Aviso de prácticas de privacidad revisado enviando una solicitud por escrito a:

**Orthopaedic Associates of Southern California**
14642 Newport Ave Suite 105 Tustin CA, 92780
Phone: (949) 688-0958 Fax: (949) 688-0960

Con este consentimiento, Orthopaedic Associates of Southern California puede llamar a mi casa u otra ubicación alternativa y dejar un mensaje o correo de voz o en persona en referencia a cualquier artículo que ayude a la práctica a llevar a cabo mi tratamiento, pago de operaciones de atención médica, como recordatorios de citas. , artículos de seguros y cualquier llamada relacionada con mi atención clínica, incluidos los resultados de las pruebas de laboratorio, entre otros.

Con este consentimiento, Orthopaedic Associates of Southern California puede enviar por correo a mi casa u otra ubicación alternativa cualquier artículo que ayude a la práctica a realizar operaciones de tratamiento, pago u atención médica, como tarjetas de recordatorio de citas y declaraciones de pacientes. Tengo derecho a solicitar que Orthopaedic Associates of Southern California restrinja la forma en que usa o divulga mi información médica protegida para llevar a cabo operaciones de tratamiento, pago u atención médica. La práctica no está obligada a aceptar mis restricciones solicitadas, pero si lo hace, está obligada por este acuerdo.

**Al firmar este formulario, doy mi consentimiento para que Orthopaedic Associates of Southern California use y divulgue mi información médica protegida para llevar a cabo operaciones de tratamiento, pago u atención médica.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Orthopaedic Associates of Southern California may decline to provide treatment to me.

_____ _____

Frima de la Paciente (o Padres/ Guardián legal) Fecha

_____ _____

Nombre de Paciente Paadres/Nombre de Guardián legal (si es aplicable)

## ACUSE DE RECIBO DEL AVISO DE PRÁCTICAS DE PRIVACIDAD DE ASOCIADOS ORTOPÉDICOS DEL SUR DE CALIFORNIA

***Al firmar este documento, reconozco que se me ha proporcionado una copia del Aviso de Prácticas de privacidad. Este aviso explica cómo este consultorio médico puede usar y divulgar mi información personal.***

**Nombre del paciente impreso: _____**

_____ _____

Frima de la Paciente (o Padres / Guardián legal) Fecha

**Orthopaedic Associates Of Southern California**
14642 Newport Ave Suite 105 Tusitn, CA 92780
11180 Warner Avenue Suite 161 Fountain Valley, CA 92708
710 N. Euclid ST. STE# 202 Anaheim, CA 92801
420 E. 3rd Street Suite 910 Los Angeles, CA 92708

# AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Date:_____ Medical Record#:_____ (For office use)

Patient Name (Please print):_____ ,_____
Last Name First Name

Address:_____

Date of Birth:_____ Telephone Number:_____

AUTHORIZATION:
I hereby authorize **Orthopaedic Associates Of Southern California** to release information of my health information to the person/organization specified below:

- ❑ Name:_____
- ❑ Name:_____
- ❑ Name:_____
- ❑ Email:_____

Mail to:
Name
_____
Address
_____ _____ _____
City State Zip Code

Release information regarding:
- ❑ All Medical Records
- ❑ Progress Notes
- ❑ Lab Test Reports
- ❑ Physical Therapy Reports
- ❑ Surgery Reports
- ❑ Other (Specify):_____
- ❑ Radiology Reports (MRI, CT Scan, X-ray, Dexa Scan, EMG)
- ❑ Radiology Film/CDs (X-ray, CT, MRI)
  ***CD is not compatible & cannot be opened by MAC computers**


Revised 12/2023

Patient Name (Please print):_____ ,_____
Last Name First Name

**The medical information/records will be used for the following purpose:

_____

**If moving, please provide new mailing address:

_____

_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/ Treatment

[ ] Limited to the following medical information:_____

DURATION:

This authorization shall be effective immediately and remain in effect until _____
DATE

RESTRICTIONS:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name and Relationship to Patient

******Please allow 48 hours for processing******

**Orthopaedic Associates Of Southern California**

---

**OFFICE USE ONLY**

Received by:_____Date Processed _____ NOTES :

_____

# PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as-provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention, of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claims, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either, party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or - (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply-to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

_____ (initial)
Patient's or Patient's Representative's Initial

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions still remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Authorized Representative's Signature DATE

Orthopaedic Associate of Southern California
Print or Stamp Name of Physician

By: _____
Patient's or Patient's Representative's Signature

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship To Patient)

# NOTICE OF PRIVACY PRACTICES
## Orthopaedic Associates Of Southern California
## 14642 Newport Ave #105 Tustin,CA 92780 |
## 710 N. Euclid Street #202 Anaheim, CA 92801 |
## 11180 Warner Ave #161 Fountain Valley, CA 92708 |
## 420 E.3rd Street #910 Los Angele s, CA 90013

**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.**

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these

communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

24. Fundraising. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can’t agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a

statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this

Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy

of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.