INLAND PULMONARY MEDICAL GROUP

Specializing in Internal Medicine, Pulmonary Medicine, Critical Care Medicine and Sleep Medicine

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Dear Sir or Madam,

Welcome to Inland Pulmonary Medical Group. We are a division specializing in internal medicine, pulmonary disease, critical care, sleep disorder, and pulmonary rehabilitation, located in the Inland Empire region.

You have an appointment scheduled with _____

On _____ at _____ am / pm

in our _____. If this is not correct, please call the office.

In order to make your appointment run more smoothly, please bring/fill out the following:

- **FORMS:** Please fill out the enclosed forms and return to our office prior to your scheduled appointment. These forms can also be downloaded from our website at www.inlandpulmonary.com
- **INSURANCE CARD:** (primary or secondary cards). We will need to make copies of your cards.
- **TEST RESULTS:** (blood work, biopsy, sleep study, MRI, CT, X-Ray, Ultrasound, PET Scan…). We may not be able to get these results the day of your appointment so please get copies of these ahead of time from your primary care physician or the facility where the test was performed.
- **FILMS:** In addition to the reports, please bring in the actual films or a disk (CD-ROM) of the imaging study for the doctor to review as well.
- **CO-PAYs:** (HMO's and other insurances that require co-pay). All Co-Pays must be paid at the time of your visit. There will be an additional processing charge for any Co-Pay billing.
- **REFERRALS:** Please ensure that your referral (if required by your insurance plan) has been obtained or put into the system by your primary care physician's office before your appointment. If you do not have a referral on the day of your appointment, it may be rescheduled.
- **MEDICATIONS:** Please bring in a complete list of current medications.

Please be aware that it is your responsibility to know the terms of your insurance contract. We participate with numerous of insurance plans, which have very different policies. Our office staff cannot be responsible for knowing your specific plan's policies.

Please keep in mind that you will be responsible to furnish all necessary information for the physician to review at the time of your visit, without this information your appointment may be cancelled and/or rescheduled for a later date. Please arrive promptly to your schedule appointment.

MANDATORY: THIS NEW PATIENT PACKET MUST BE RETURNED BY MAILING, FAXING, OR EMAILING IT BACK TO OUR OFFICE PRIOR TO YOUR APPOINTMENT WITH PHYSICIAN. FAILING TO PROVIDE COULD RESULT IN RESCHEDULING YOUR APPOINTMENT. THANK YOU FOR YOUR COOPERATION.

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, A 24-HOUR NOTICE IS ABSOLUTELY MANDATORY. PLEASE CALL THE PHONE NUMBER BELOW TO INFORM OUR STAFF OF ANY CHANGES. SHOULD YOU FAIL TO DO SO, A $35 CANCELLATION FEE FOR NEW PATIENTS/$25 CANCELLATION FEE FOR FOLLOW-UP PATIENTS/ $50 PFT CANCELLATION /$100 NO-SHOW FEE FOR NEW PATIENTS /$50 NO-SHOW FOLLOW-UP PATIENTS/$100 FOR NO SHOW PFT WILL BE DIRECTLY BILLED TO YOU. HEALTH INSURANCES DO NOT COVER THIS EXPENSE.

Thank you. We look forward to meeting you and taking care of you.

9655 Monte Vista Avenue, Suite 402 Montclair, CA 91763 * (909) 626-1205 * Fax (909) 625-1977
637 N. 13th Avenue, Upland, CA 91786 * (909) 985-9321 * Fax (909) 985-0842
Web site: www.inlandpulmonary.com

INLAND PULMONARY MEDICAL GROUP

NEW PATIENT INFORMATION

Last Name_____ **First Name** _____ **M.I.** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Soc. Sec. # _____ **Age** _____ **DOB** _____ **Phone #** _____

CA DL# _____ **Marital Status:** ☐ Married ☐ Widow ☐ Divorce ☐ Single ☐ Separated ☐ Dating

Gender: ☐ Male ☐ Female Race: _____ **Religion**: _____

Ethnicity: _____ **Preferred Language:** _____ ☐ **Refused** ☐ **Decline**

Preferred Pharmacy Name/Address: _____

Employer _____ **Occupation** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

PRIMARY INSURANCE
Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

SECONDARY INSURANCE
Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

INSURED PARTY INFORMATION IF DIFFERENT THAN ABOVE

Name _____ **Phone #** _____

DOB _____ **Soc. Sec. #** _____ **Relation** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Ins. Co. Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

EMERGENCY CONTACT:

Name _____ **Relation**: _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

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INLAND PULMONARY MEDICAL GROUP

9655 Monte Vista Avenue, Suite 402, Montclair, CA 91763 ● 637 North Thirtieth Avenue, Upland, CA 91786

Financial Agreement: I, the undersigned, hereby authorize you to make payments directly to Dr. Hsu, Dr. Hong, Dr. Kongchalalai, Dr. Chang, Dr. Grobler, Dr. Khorrami, and Dr. Gaffar for all basic and major medical expenses. I fully understand that I am financially responsible for any balance.
Medical Records: I, the undersigned, hereby grant authorization for the release of any information required to process the medical claims. A copy of this authorization is as valid as the original.
Consent for Treatment: I, the undersigned, hereby consent to the administrator of and performance of all diagnostic procedures and treatment, which, in the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my attending physician, the physician will not be liable for the consequences of such decision.

_____ _____

Patient or Responsible Party Signature **Date**

INLAND PULMONARY MEDICAL GROUP

OFFICE FINANCIAL POLICY

We are committed to providing all our patients with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

ALL PATIENTS: The patient is responsible for all services rendered regardless of insurance coverage. The full responsibility of payment rests with you, the patient or responsible party.

CASH PATIENTS: All services rendered on a cash basis must be paid in full at the time of service.

PRIVATE INSURANCE: We must have a fully completed and signed insurance form at the time of service. If you cannot supply us with all the necessary billing information, your account will be handled the same as a cash patient. Deductible and co-payment amounts are due at the time of service.

MEDICARE: We must have a copy of your Medicare card and any secondary insurance(s). We do accept assignment on Medicare claims, which means that you will be responsible only for your deductible and 20% of allowed charges. There are certain procedures and supplies, which are NON-COVERED services for Medicare patients. If you need such services you will be informed that they are NON-COVERED and if you still wish to receive such services in this office they will be on a cash basis at the time of service.

IF AT ANY TIME YOU SHOULD EXPERIENCE FINANCIAL HARDSHIP, PLEASE MAKE THIS OFFICE AWARE OF THE SITUATION. WE ARE ALWAYS WILLING TO MAKE SPECIAL ARRANGEMENTS FOR THOSE PATIENTS WHO NEED EXTRA HELP. IF YOU NEED TO MAKE ARRANGEMENTS, PLEASE ASK TO SPEAK WITH THE BILLING SUPERVISOR OR MANAGER.

I have carefully read and understand all of the above and accept, approve, and agree to **Inland Pulmonary Medical Group** *Office Financial Policy*.

_____ _____

Patient or Responsible Party Signature **Date**

INLAND PULMONARY MEDICAL GROUP

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **DATE:** _____

DOB: _____ **AGE** _____ **SEX** _____ **HT.** _____ **WT.** _____

CHIEF COMPLAINT/ REASON FOR TODAY'S VISIT:

_____

_____

_____

_____

ALLERGIES:

_____

SURGICAL HISTORY:

_____

PAST MEDICAL HISTORY:

Major Illness/Date of Onset: _____

Major Injuries/Date of Onset: _____

Positive TB:	☐ Yes	☐ No	Date of Onset: _____
Do you snore?	☐ Yes	☐ No	Date of Onset: _____
Are you excessively tired during the day?	☐ Yes	☐ No	Date of Onset: _____
Have you been told you stop breathing during sleep?	☐ Yes	☐ No	Date of Onset: _____
Do you have history of hypertension?	☐ Yes	☐ No	Date of Onset: _____
Is you neck size >17in (male) or >16in (female)?	☐ Yes	☐ No	Date of Onset: _____

FAMILY HISTORY:

Lung Disease	☐ Yes	☐ No	Who? _____ Age of Onset: _____
Heart Disease	☐ Yes	☐ No	Who? _____ Age of Onset: _____
Diabetes	☐ Yes	☐ No	Who? _____ Age of Onset: _____
Cancer	☐ Yes	☐ No	Who? _____ Age of Onset: _____
Cancer Type: _____			
Blood Pressure	☐ Yes	☐ No	Who? _____ Age of Onset: _____
Positive TB	☐ Yes	☐ No	Who? _____ Age of Onset: _____

TOBACCO USE: Quit? ☐ Yes ☐ No If so, when? _____

Smoke Cigarettes: ☐ Never ☐ Yes ☐ No Quit Date: _____ How Long: _____ # Packs: _____ # Cigs: _____

OTHER TOBACCO:

Cigar	☐ Never ☐ Yes ☐ No	Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____
Pipe	☐ Never ☐ Yes ☐ No	Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____
Snuff	☐ Never ☐ Yes ☐ No	Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____
Chew	☐ Never ☐ Yes ☐ No	Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____

ALCOHOL USE: ☐ Yes ☐ No Quit Date: _____ **How often:** ☐ Daily ☐ Frequently ☐ Social ☐ Rarely

DRUG USE:

Do you use marijuana or recreational drugs? ☐ Yes ☐ No Type: _____

Have you ever used needles to inject drugs? ☐ Yes ☐ No Type: _____

PLEASE LIST ANY PRIOR (*MOST RECENT*) HOSPITALIZATIONS:

_____

REFERRING PHYSICIAN: _____

INLAND PULMONARY'S PHYSICIAN SIGNATURE: _____ **DATE**: _____

CURRENT MEDICATION RECORD

Patient Name: ____

Date of Birth: ____

Today's Date: ____

MEDICATIONS: Please list all medications you currently take, including appetite suppressants, vitamins, etc.

MEDICATION NAME	STRENGTH	FREQUENCY	START/END DATE	PRESCRIBING PHYSICIAN	DISPENSING PHARMACY

SLEEP AND DIAGNOSTIC CENTER

INLAND PULMONARY MEDICAL GROUP

Epworth Sleepiness Scale

Date____/____/_____

Take a moment to think about day-to-day life over the past few weeks. How likely are you to doze off or fall asleep verses just feeling tired while participating in a situation that requires your attention, such as driving, reading, or attending a meeting?

The *Epworth Sleepiness Scale* presents various daily situations and asks you to rate your degree of sleepiness in each circumstance. Even if you have not done some of these things recently, try to think about how they would affect you. Use the following scale to choose the most appropriate number for each situation.

Name: _____

Date of Birth: _____/_____/_____

Age: _____

Gender: ☐Male ☐Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = ***no chance*** of dozing
1= ***slight*** chance
2 = ***moderate*** chance
3 = ***high*** chance

Situation	**Chance of dozing (0 – 3)**			
Sitting and reading	0 ◉	1 ○	2 ○	3 ○
Watching TV	0 ◉	1 ○	2 ○	3 ○
Sitting, inactive in a public place (e.g., theater or meeting)	0 ◉	1 ○	2 ○	3 ○
As a passenger in car for 1 hour with no break	0 ◉	1 ○	2 ○	3 ○
Lying down to rest in the afternoon	0 ◉	1 ○	2 ○	3 ○
Sitting and talking to someone	0 ◉	1 ○	2 ○	3 ○
Sitting quietly after lunch without alcohol	0 ◉	1 ○	2 ○	3 ○
In a car, while stopping for a few minutes in traffic	0 ◉	1 ○	2 ○	3 ○

Total Score____

INLAND PULMONARY MEDICAL GROUP
Patient Consent Form
Notice of Privacy Practices

9655 Monte Vista Avenue, Suite 402, Montclair, CA 91763
637 North Thirtieth Avenue, Upland, CA 91786
Dania Tabikha, Privacy Officer, Phone: (909) 626-1205

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

☐ Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

_____

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

_____

_____

INLAND PULMONARY MEDICAL GROUP
PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home Telephone No. _____
- ☐ Acceptable to leave message with detailed information.
- ☐ Leave message with call back number only.

☐ Work Telephone No. _____
- ☐ Acceptable to leave message with detailed information.
- ☐ Leave message with call back number only.

☐ Written Communication
- ☐ Acceptable to mail to my home address.
- ☐ Acceptable to mail to my work/office address.
- ☐ Acceptable to fax to this number _____

☐ Other _____
_____

I authorize Inland Pulmonary Medical Group physicians and/or staff to disclose *PHI* to the following members of my family or person/s responsible for my healthcare (check all that apply):

☐ Spouse: Name _____
☐ Daughter/s: Name/s _____
☐ Son/s: Name/s _____
☐ Extended Care Facility _____
☐ Other: _____
_____

_____ _____
Print Name **Date of Birth**

_____ _____
Patient Signature **Date**

INLAND PULMONARY MEDICAL GROUP
REQUEST FOR RELEASE OF MEDICAL RECORDS

PLEASE RELEASE RECORDS TO:

☐ Inland Pulmonary Medical Group
9655 Monte Vista Avenue, Suite 402
Montclair, CA 91763
Phone: (909) 626-1205
Fax: (909) 625-1977

☐ Inland Pulmonary Medical Group
637 North 13th Avenue
Upland, CA 91786
Phone: (909) 985-9321
Fax: (909) 985-0842

☐ _____
_____
_____
_____
Phone No. _____
Fax No. _____

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

☐ Consultation
☐ History and Physical
☐ Progress Notes
☐ Treadmill Test
☐ Holter
☐ EKG
☐ Laboratory
☐ Pulmonary Function Test
☐ X-Ray
☐ CT Scan
☐ PET Scan
☐ Any and all Radiology

Other: _____

Date: _____

Patient Name (Please Print): _____

Date of Birth: _____

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES

Inland Pulmonary Medical Group, 9655 Monte Vista Avenue, Suite 402, Montclair, CA 91763, 637 North 13th Avenue, Upland, CA 91786

Dania Tabikha, Privacy Officer Phone: (909) 626-1205

Effective Date: 08/08/2016

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. **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.
8. **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.

9. **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.
10. **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.
11. **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.
12. **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.
13. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
14. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
15. **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.
16. **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.
17. **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.
18. **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.
19. **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.
20. **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.

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. We will also post the current notice on our website.

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.