Sleep & Diagnostic Center

9655 Monte Vista Ave. Ste 402B
Montclair, CA 91763
LAB (909) 670-0472, OFFICE (909) 626-1205, FAX (909) 670-0473

Dear _____ Today's Date: _____

You are scheduled to have a sleep study at *Sleep & Diagnostic Center* on _____ at _____ **P.M.**

*If for any reason you need to cancel or reschedule a **48-HOUR NOTICE IS MANDATORY**. Please inform our staff of any changes. If you fail to do so, a $175.00 cancellation fee or $300.00 no show fee will be directly billed to you. Health plan insurances do not cover these types of expenses.*

About Polysomnography:

ABOUT POLYSOMNOGRAM (Sleep Study): A Polysomnogram is a measurement of brain waves, eye movement, muscle activity, heart rate, and respiratory function. A sleep disorder can have an adverse effect on ones health and quality of life, which may include disrupted sleep apnea. If left untreated, it may result in hypertension, headaches, stroke, heart attack, fatigue related to vehicle and work accidents, and decrease in quality of life.

If your physician orders what is called a "split study," this means that if you stop breathing (obstructed sleep apnea) a certain amount of times during the sleep study or your oxygen levels drop, we will use a device called a CPAP (Continuous Positive Airway Pressure) to establish the appropriate pressure if you snore. We will show you a video before you go to bed that will explain this device and the reason for its use in more detail.

WHAT TO EXPECT: It takes approximately 45 minutes to 1 hour to get you "hooked-up." Surface electrodes will be applied to your scalp, chin, legs, and near your eyes. This will enable us to evaluate your brain waves, muscle tone and sleep stages. Respiratory monitoring devices will be placed on you to monitor nasal airflow and chest movement. This is necessary to identify any apnea (cessation of breathing) during your sleep. Your heart will also be monitored. Once the set up is complete, you will be able to read, watch T.V and/or simply relax for a while. Once you go to sleep, a sleep technician will monitor you from the control room, while you sleep. We prefer lights out by 10:30 p.m. We would like you to sleep at least six hours or more.

If you have an upper respiratory infection (e.g. coughing, congestion, fever, etc.) please notify us 24 hours prior to your appointment to cancel or reschedule. If you fail to do so, a fee will be directly billed to you. Health plan insurances do not cover these types of expenses.

PREPARATION:

- Avoid caffeine drinks 8-12 hours prior to testing. (e.g. coffee, tea, soda, chocolate, etc.)
- Avoid alcoholic beverages 24 hours prior to testing
- Avoid sleeping tablets or tranquilizers (if you take any sleeping aids please bring them with you at the time of your visit.)
- Please arrive showered with hair clean and dry.
- Please eat a good meal prior to your stay with us.

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PLEASE BRING:

- The attached questionnaire packet (completed)
- Any medications prescribed by your physician that are required to be taken
- Comfortable sleep attire – **REQUIRED**
- Your favorite pillow – **REQUIRED**
- A bottle of water.
- Regular day clothing for the next day, if desired.
- Please bring any necessary hygiene products such as toothpaste, toothbrush, soap, etc.

ATTACHED TO THIS PACKAGE PLEASE FIND:

- Our office Privacy Policy (for you to keep).
- A 5-page questionnaire (that needs to be completed) and brought to our office the night of your study.
- An Epworth Sleep Scale (needs to be completed and brought to our office the night of your study).
- Frequently asked questions about Sleep Studies.

We hope this information is helpful and answers most of your questions. Should you have any questions, please contact us at (909) 670-0472.

Sincerely,

Sleep & Diagnostic Center Staff

DIRECTIONS TO OUR FACILITY

From Los Angeles:

Take the I- 10 East, Exit Monte Vista Avenue off ramp. Turn Right. Proceed approximately 100 yards south and make a left. We are east of the Monte Vista Pharmacy.

From San Bernardino:

Take the I- 10 West, Exit Monte Vista Avenue off ramp. Turn Left. Proceed approximately 100 yards south and make a left. We are east of the Monte Vista Pharmacy.

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

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

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

CA DL# _____ **Marital Status:** M ☐ S ☐ W ☐ D ☐ Separated ☐ Dating ☐ **Gender:** ☐ Male ☐ Female

Race: _____ **Religion:** _____ **Ethnicity:** _____

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** _____

FRIEND OR RELATIVE IN THE AREA

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

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

****

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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. Siriratsivawong 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**

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Most Frequently Asked Questions about Sleep Studies

1. **Why do I need a Sleep Study?**
   Your doctor believes you show signs of sleep apnea, or he/she wants to rule out sleep apnea. Indications of sleep apnea are: excessive daytime sleepiness, snoring, gasping for breath during sleep and difficulty falling asleep. These are just a few symptoms associated with sleep apnea.

2. **What is a Sleep Study?**
   A sleep study is a diagnostic test using elements and wires that provide several types of measurements used to identify different sleep stages and classify various sleep disorders. This procedure is not painful or uncomfortable and is very safe. Small sensors are connected to the head, face, chest and legs of the patient to monitor different brain and body activities including brain waves, eye movement, heart rate, respiration and muscle movements.

3. **Can I fall asleep with all those wires on me?**
   Every effort is made to make the study as comfortable as possible so that it feels like another night to you. The sensor wires are gathered together to make it easy for the patient to roll over and change position. After a few minutes in bed, you will not even feel the presence of the sensors, and they can be easily disconnected if you need to go to the bathroom in the middle of the night.

4. **What should I expect during my sleep study?**
   While the patient is sleeping, various important body functions and data are being monitored and recorded. All the information gathered via the sensors are fed into the computer. The technician is monitoring the equipment throughout the duration of study in a separate room. Our technologists are experts in sleep recording procedures and will be happy to answer any questions you may have. Depending on your sleep study if a respiratory or breathing problem is observed during sleep the patient can be woken up to try a device that treats breathing problems. This device is a Continuous Positive Airway Pressure (CPAP), which includes a small mask that fits around the nose.

5. **Will I need to take my medications the night of my sleep study?**
   Yes. The patient should not discontinue any prescription medication without consulting his/her doctor first. However, it is important that the patient write down in the questionnaire that she/he is given before the sleep study, any medication that he/she has been taking. If you are beginning a new medication that you have not taken for more than a week please let our technician know, to insure it does not affect your sleep pattern.

6. **Are there any recommendations that I should follow on the day of my sleep study?**
   It is important that the patient's hair is thoroughly dry and free of oils or sprays for the study. We recommend that the patient not take any naps on the day of the study and should limit themselves to 2 caffeinated beverages (including coffee, tea, or soft drinks containing caffeine) 12 hours prior to the study. No alcoholic beverages should be consumed on the day of the study.

7. **What should I expect after my sleep study?**
   About 5 - 14 business days after a sleep study, the results will be compiled and forwarded to your physician. Your physician will then go over the results with you and make his/her recommendations. Please note that the technologist performing the study will not have any information regarding your diagnosis.

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Name: _____ Occupation: _____ Age: _____
Date of Birth: _____

Gender: (Circle) Male / Female
Height: _____ Weight: _____ Weight in High School: _____ Neck Size: ____ in.

Main Sleep Complaint (Circle): Daytime Fatigue / Insomnia / Snoring/ Tossing and Turning/ Night Sweats / Restless Legs / Frequent Awakenings / Other_____

Physician's Name_____

How did you hear about us? _____

Past Medical History: Check all that apply to you. Give dates as necessary (e.g. high blood pressure 2002)

____ Hypothyroidism, ____ Heart disease, ____ Hypertension, ____ Hiatal hernia, ____ Heartburn, ____ Kidney disease, ____ Stroke, ____ Head Trauma, ____ Diabetes, ____ Seizure, ____ Arthritis, ____ Cancer, ____ Tuberculosis, ____ Emphysema, ____ Meningitis, ____ Sleep disorder- If yes, please indicate which disorder(s):
Sleep apnea ☐ Narcolepsy ☐ Restless legs ☐ Insomnia ☐ Other ☐ _____

List Current Medications: Please include all intermittent over the counter medications.

Name	Amount	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Name: _____ Date of Birth: _____

Please mark "x" in the 2nd column if you have the symptom indicated in the 1st column:

Snoring	☐
Unrefreshing sleep	☐
Witnessed stop breathing	☐
Waking up choking or gasping for air	☐
Acid reflux in the night	☐
Frequent urination in the night	☐
Excessive sweating in the night	☐
Sleep talking	☐
Morning dry mouth	☐
Morning headache	☐
Difficult to fall asleep	☐
Difficult to maintain sleep	☐
Early morning awakening	☐
Thinking too much at sleep onset	☐
Worrying about things while in bed	☐
Fear of not being able to fall asleep	☐
Fear of not being able to fall back to sleep	☐
Fall asleep unexpectedly	☐
Sleep attack (sudden irresistible sleep)	☐
Falling asleep while driving	☐
Muscle weakness provoked by laughter	☐
Muscle weakness triggered by strong emotion	☐
Unable to move while waking up	☐
Unable to move while falling asleep	☐
Seeing floating images as you are falling asleep	☐
Seeing floating images while you are just waking up	☐
Floating images that persist when your eyes are open	☐
Grinding teeth while you are asleep	☐
Leg cramps (Charley horse) in the night	☐
Crawling sensation in legs when you are resting	☐
Leg crawling sensation relieved by movement	☐
Legs kicking at night	☐
Nightmares (extremely frightening dreams)	☐
Sleep terror (awaken frightened, no dream)	☐
Acting out dream	☐
Dream enactment with arm flailing or leg moving	☐
Dream enactment with injury	☐
Tongue biting in sleep (bloody pillow)	☐
Wake up in the night in a unusual posture	☐
Napping routinely	☐
Unrefreshing naps	☐

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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: _____/_____/_____
Your age: _____
Your sex: ☐ 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:

Chance of dozing (0 – 3)
0 = **no** chance of dozing
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

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_____

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PATIENT CONSENT FORM
NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the health insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining authorization and/or payment from party payers(e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations. You are not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

"I acknowledge that I have received a copy of the Notice of Privacy Practices from Inland Pulmonary Medical Group, Sleep and Diagnostic Center."

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

INLAND PULMONARY MEDICAL GROUP
SLEEP AND DIAGNOSTIC CENTER
9655 Monte Vista Avenue, Suite # 402B
Montclair, CA 91763
Phone: 909-670-0472
Fax: 909-670-0473

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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 communication or that a communication of *PHI* is 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 matter (check all that apply):

- ☐ Phone No. _____
- ☐ I give permission to Sleep & Diagnostic physician/staff to leave messages with detailed information.
- ☐ I give permission to Sleep & Diagnostic Staff to leave message with call back number only.
- ☐ Phone No. _____
- ☐ I give permission to Sleep & Diagnostic Staff to leave message with detailed information.
- ☐ I give permission to Sleep & Diagnostic Staff to leave message with callback number only.
- ☐ Written Communication
- ☐ I give permission to Sleep & Diagnostic Staff to mail to my home address.
- ☐ I give permission to Sleep & Diagnostic Staff to mail to my work/office address.
- ☐ I give permission to Sleep & Diagnostic Staff to fax to this number _____
- ☐ Other: _____

I authorize Sleep & Diagnostic Center/ 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**

_____ _____
Patients Signature **Date**

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TO: Sleep & Diagnostic Center
9655 Monte Vista Avenue, Suite 402B
Montclair, CA 91763
Phone: (909) 670-0472
Fax: (909) 670-0473

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

CONSULT ☐ LABS ☐

TREADMILL ☐ PFT ☐

HOLTER ☐ BILLING ☐

EKG ☐ OTHER _____

X-RAY ☐ _____

PLEASE RELEASE THE ABOVE REQUESTED RECORDS TO:

AUTHORIZED SIGNATURE _____

PRINT NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

DATE SIGNED _____

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To: _____
_____
_____
_____

Phone: _____
Fax: _____

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

Consult_____☐_____ Labs_____☐_____

Treadmill_____☐_____ PFT_____☐_____

Holter_____☐_____ Progress Notes_____☐_____

EKG_____☐_____ X-Ray_____☐_____

Other_____

PLEASE RELEASE THE ABOVE RECORDS TO:

9655 Monte Vista Avenue, Suite 402A
Montclair, CA 91763
Phone (909) 670-0472 Fax (909) 670-0473

Patient's Name (Please Print):_____

Patient's Date of Birth: _____

Patient's Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

Sleep & Diagnostic Center, 9655 Monte Vista Avenue, Suite 402A, Montclair, CA 91763

Ana Mendoza, Privacy Officer Phone: (909) 626-1205/ (909) 670-0472

Effective Date: April 05, 2017

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.

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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.