Lewis J. Kanter, M.D.
Cristina N. Porch-Curren, M.D.
Christine Y. Lee-Kim, DO
Diplomate Of The American Board Of Allergy & Immunology
And Associates
• Camarillo 805-482-8989; FAX (805) 987-2855
• Thousand Oaks (805) 493-1537
• Simi Valley (805) 581-6482

WELCOME TO OUR PRACTICE!

Updated 3.5.19

We feel a good relationship is essential to your overall care. With this in mind, we have assembled information to help acquaint you with our office, staff and policies.

You can help us get to know you and assess your medical needs by completing the enclosed medical history and patient information forms. Please fill these out *completely* and be sure to bring them when you come in for your first visit.

We have scheduled your appointment at the date, time and location below:

Date/Day:____________________ Time:________________ w/ Dr. Kanter or Dr. Porch or Dr. Lee

☐ Camarillo ☐ Thousand Oaks ☐ Simi Valley

Your first visit will consist of a consultation and exam with the doctor. At that time the doctor will determine if any diagnostic or allergy testing is necessary to complete the evaluation. The initial evaluation (including testing) may take up to three hours. If testing is not done, it will take approximately 1-1/2 to 2 hours. It is *preferable* that you do not take any antihistamines for **7 DAYS** prior to the appointment: Xyzal, Claritin/Clarinex/Alavert/AllerClear, Benadryl, Atarax (hydroxyzine), Allegra/fexofenadine/Allerflex, Dymista, Patanase, Astepro, Zyrtec/Cetirizine/Allertec, Astelin NS & for Afrin NS; Eye Drops such as Pazeo, Pataday, Patanol, Zaditor, etc. Sleeping pills and cold medications may contain antihistamines that may interfere with the allergy testing process, please refrain from taking **7 DAYS** prior to your visit. Certain heartburn medications (Tagamet, Axid, Pepcid(famotidine), Zantac(ranitidine)) contain antihistamine and should also be discontinued. If you are taking any of the above medication we still want to see you on the day of your scheduled appointment. Testing can be scheduled at a later time if necessary.

We strongly suggest you bring all your recent medications including OTC (over the counter) medicines and Herbals with you to the appointment, whether you are taking them or not, for us to review with you.

Please bring your ***insurance card, photo identification (Driver's license/utility bill)*** and authorization (if applicable). It is the policy of our office to collect your copay at the time of your visit. It is in your best interest to contact your insurance company regarding services with a specialist so you will be aware of your financial responsibilities. Special financial arrangements can be made with our business office if needed.

Due to the time allotted and staffing for your appointment, we require 24 business hours cancellation notice to avoid a $25.00 charge for last minute cancellations or broken appointments. We look forward to meeting you and providing you with the best of care. Please visit us at our website www.allergycc.com. At the ***Coastal Allergy Care*** we believe patients come first!

Sincerely,
The Coastal Allergy Care Staff

PATIENT REGISTRATION INFORMATION

LAST NAME:______________________________ **FIRST** NAME:________________________ **MI**:______

SOCIAL SECURITY #_______________ BIRTHDATE :____/____/____MARITAL STATUS_____CA DRIVER'S LIC#:__________

ADDRESS:_________________________________CITY:_______________STATE/ZIP:____________

CELL #:______________HOME PHONE:________________WORK PHONE #:__________ E-MAIL:_________________

EMPLOYER:_______________________________CITY:________________________STATE/ZIP:___________

REFERRING/PRIMARY CARE MD:____ PHONE:_________________

PHARMACY: ________________________ PHONE: __________________ ADDRESS/CITY: _________________

CAC Office Staff:
ID: DL#____________________ **OR** Utility (Name/Acct#):____________________ Address Verified (initial)__________

PARENT/SPOUSE/RESPONSIBLE PARTY ***(FILL OUT ONLY WHERE DIFFERENT FROM PATIENT)***

HUSBAND/FATHER:____________________________ WIFE/MOTHER:____________________________

ADDRESS:_________________________________ ADDRESS:_________________________________

CELL PHONE:______________BIRTHDATE:____________ CELL PHONE:______________BIRTHDATE:____________

SOC SEC#:_________________________________SOC SEC#:_________________________________

EMPLOYER:____________ WORK PHONE:____________ EMPLOYER:____________WORK PHONE:____________

SECTION BELOW MUST BE COMPLETE TO BILL INSURANCE

INSURANCE INFORMATION

PRIMARY INSURANCE :____________________________ID:________________ EFFECTIVE DATE:__________

Subscriber Name & Birthdate:____________________________________RELATIONSHIP TO PATIENT:____________

PPO / EPO ❒ Medicare ❒ Tricare ❒ VCHCP ❒ ValleyCare IPA ❒ ValleyCareSelect ❒ HMO ❒ (We Do NOT Accept)

SECONDARY INSURANCE:____________________________ ID:________________ EFFECTIVE DATE:__________

Subscriber Name & Birthdate:____________________________________RELATIONSHIP TO PATIENT:____________

PPO / EPO ❒ Medicare ❒ Tricare ❒ VCHCP ❒ ValleyCare IPA ❒ ValleyCareSelect ❒

HOW DID YOU HEAR ABOUT COASTAL ALLERGY CARE?____

FRIEND OR RELATIVE FOR EMERGENCY CONTACT (NOT LIVING WITH YOU):_______________________________

ADDRESS:____DAYTIME PHONE:____________

The practice of Coastal Allergy Care will bill your insurance company as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event that services rendered are not covered by your insurance company, we will require that you remit payment to Coastal Allergy Care. Additionally, if your insurance company does not remit payment in a timely manner (within 60 days from the time your claim is billed), we will transfer the balance to your responsibility and require that you remit payment to Coastal Allergy Care for all outstanding insurance balances over 60 days. The outstanding balances may include, but are not limited to:

- Office visit co-payments
- Annual deductibles
- Services that are not covered by your health plan
- Interest charges from overdue patient due balances

I, THE UNDERSIGNED, AUTHORIZE PAYMENT BY THE ABOVE NOTED INSURANCE COMPANY(S) BE MADE DIRECTLY TO COASTAL ALLERGY CARE, INC., FOR ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR ALL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY SAID INSURANCE, INCLUDING DEDUCTIBLE AND COPAYMENTS. ***A $25.00 FEE WILL BE CHARGED FOR APPOINTMENTS CANCELLED WITHOUT A MINIMUM OF 24 BUSINESS HOURS NOTIFICATION.*** I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I FURTHER AGREE IN THE EVENT OF NON-PAYMENT OF ANY AMOUNTS DUE BY ME, TO BEAR THE COST OF COLLECTION, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED. ***I ACKNOWLEDGE RECEIPT OF CAC PRIVACY PRACTICES.*** I WILL NOTIFY CAC OF ANY INSURANCE CHANGE

SIGNED:____DATE:________________

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PATIENT INFORMATION AND CONSENT FORM

There are three main forms of treatment for allergic diseases: avoidance, medication, and allergy injection therapy.

ALLERGY SKIN TESTING- The skin tests most frequently used are prick and/or intradermal (needle). Prick tests involve a tiny puncture through a drop of allergy extract. The area is then observed for about 15-20 minutes. Positive reactions usually manifest as an area of redness and itching at the prick test site. Intradermal tests involve the injection of a tiny amount of extract into the skin through a small needle. These tests are usually more sensitive than prick tests and a positive test resembles that described for a positive prick test.

Local reactions to allergy skin testing such as redness, swelling, and itching are common.

A general/systemic reaction due to allergy testing, although extremely rare, can occur and is described in the section on allergy injection therapy.

MEDICATIONS- Different medications may be used in treating allergy symptoms. There can be possible undesirable side effects due to overuse or unsupervised administration. Side effects of some frequently used antiallergic drugs include:

1. Antihistamines: Drowsiness, interference in operating machines, including automobiles.
2. Bronchodilators: Nervousness, restlessness, upset stomach.
3. Adrenalin (Epinephrine)/Decongestants: Pallor, rapid heart rate, nervousness, trembling, shaking and sleeplessness.
4. Corticosteroids (Cortisone, Prednisone, etc.): Undesired weight gain, peptic ulcers, suppression of the adrenal gland, reactivation of pre-existing tuberculosis, growth retardation, hypertension, increased blood sugar, and other disturbances. Risks are greatly minimized by the use of small doses for short periods or intermittent rather than by daily administration. Risk is increased with large doses given daily over a long period of time. The risk is much lower with inhaled or nasal steroids as the dose is much lower.
5. Aerosols for inhalation: Restlessness, pounding heart, and loss of effectiveness, especially if taken more frequently or in greater amount than prescribed. Overdosing may cause fatal heart irregularities.

Many of the aforementioned side effects are due to over dosage.

ALLERGY INJECTION THERAPY- The purpose of allergy injection therapy is to decrease sensitivity to substances that cause allergy symptoms.

A treatment set of extract/antigen vials are prepared for the patient based upon their individual test results. When a patient is allergic to many different substances, it is necessary to divide the materials into two or three different sets of vials. Injections are started using the weakest dilution and the progresses to more concentrated doses until a maintenance dose is reached. After a maintenance dose is reached, the interval between injections is progressively spaced and then continued for years. Allergy injections are recommended for an average of three years, therefore, requiring an ongoing commitment.

It should be emphasized that immunotherapy does not cure allergies and that immediate improvement is not to be expected. It takes approximately six months for the average patient to begin demonstrating the positive effects of the injections. Please realize that we are aiming for long term improvement. Although some patients do not respond adequately to immunotherapy, most experience a significant decrease in symptoms.

REACTIONS TO IMMUNOTHERAPY- A local reaction at the injection site is common and usually occurs soon after the injection as an area of redness or swelling. These local skin reactions will generally resolve over several hours or, in rare instances, a few days. If an unusually large local reaction occurs, or lasts many hours, or is accompanied by sneezing or coughing, it may indicate a change in dosage should be made. Any local reaction symptoms MUST be reported to the nurse prior to receiving your next allergy injection.

General/systemic reactions can occur but are extremely rare. In addition to sneezing or coughing, a general reaction may include, widespread itching, hives, nasal discharge, wheezing, difficulty breathing, low blood pressure, and rarely shock. These symptoms, while potentially serious and in rare instances, life threatening, generally respond well to treatment.

You will be required to remain in the waiting room for at least twenty (20) minutes following your injection in order to record and/or treat any reaction which may occur. IF YOU HAVE SEVERE SYMPTOMS AFTER LEAVING THE OFFICE, GO IMMEDIATELY TO THE EMERGENCY ROOM.

Allergy injections should generally not be given when significant wheezing or fever are present. YOU MUST INFORM THE STAFF IF YOU ARE TAKING BLOOD PRESSURE OR MIGRAINE MEDICATION OF THE BETA-BLOCKER TYPE as this may put you at higher risk for adverse reaction to allergy injections.

I do hereby certify that I have read and understand the above information regarding allergy skin testing, allergy medications, and allergy injection therapy. I am aware of the possible benefits and risks involved.

In addition, I understand that upon agreeing to allergy injection therapy an antigen treatment set of 5 to 15 vials will be made for me and that I am financially responsible for these vials.

I have been given a copy of this information and consent form and have had the opportunity to ask questions and/or discuss my treatment with the doctor.

________________________	________________________	____________
SIGN PATIENT OR GUARDIAN	PRINT PATIENT NAME	DATE
________________________	________________________	____________
WITNESS	PRINT WITNESS NAME	DATE

PATIENT -PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: 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 right to have such dispute decided in a court of law before a *jury,* and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services 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. This includes, but is not limited to , all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person . I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation .or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same imm!Jnity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association , 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org . I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below. Earlier effective date: Patient's Initials: _ _ ___

ARTICLE 7: I have read and understood all of the information in this pamphlet, including the Introduction to the PatientPhysician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the tenn "patient" as used herein means both the mother and the mother's expected child or children.

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

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.

____ Dated: ____________

(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: ____

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

____ Dated:_______________

(Physician or Duly-Authorized Representative)

______________________________ ____

Title-e.g., Partner, President, etc. **Print name of Physician, Medical Group, Partnership or Association**

PATIENT ALLERGY HISTORY – Page 1 (updated 3.5.19)

Patient Name:______________________________________(DOB)__________________ Todays Date:_____________________

Primary Physician:_________________________ Referring Physician:_________________________

Age:______________________ Occupation:_________________________ Sex Assigned at Birth: ❒ Male ❒ Female

Patient's Chief Patient's Complaint: ____

____

____

Past Medical History

❒Allergies (nose/eyes)
❒Anemia/low red cells
❒Angina (heart-related chest pain)
❒Anxiety/depression
❒Arthritis
❒Asthma
❒Atrial fibrillation
❒Autoimmune disease
❒Benign prostate enlargement
❒Blood clots
❒Cancer ___________
❒Stroke
❒COPD/emphysema
❒Heart dieseae
❒Crohn's Disease
❒Diabetes
❒Gallbladder disease
❒Heartburn
❒Hepatitis A
❒Hepatitis B
❒Hepatitis C
❒High cholesterol
❒High blood pressure
❒Irritable bowel
❒Liver Disease
❒Migraine headaches
❒Heart attack
❒Osteoporosis
❒Peptic ulcer disease/stomach ulcers
❒Pneumonia
❒Kidney disease _________________
❒Multiple Sclerosis
❒Seizure disorder
❒Thyroid disease _________________
❒Tuberculosis
❒Other ____

Past Surgical History

❒Adenoidectomy
❒Angioplasty
❒Angioplasty +stent
❒Appendectomy
❒Back surgery
❒Coronary bypass
❒Carpal tunnel
❒Cataract
❒Gall bladder
❒Cholecystectomy
❒Colectomy
❒Colostomy
❒Hernia repair
❒Knee replacement
❒LASIK
❒Liver biopsy
❒Ear tubes
❒Fracture repair
❒Pacemaker
❒Sinus surgery
❒Small bowel resection
❒Thyroidectomy
❒Tonsillectomy
❒Breast augmentation
❒Tubal ligation
❒Breast biopsy
❒C-Section
❒D and C (Uterus)
❒Hysterectomy
❒Mastectomy
❒Fibroid removal
❒Breast reduction
❒Hysterectomy and ovary removal
❒Vaginal hysterectomy
❒Prostate biop.
❒Prostate
❒Vasectomy
❒Other ____

Family History

❒Check if Adopted

	Mother	Father	Sister	Brother	Children	Other Relative
Allergies – nasal or eye						
Asthma						
COPD, emphysema or cystic fibrosis						
Eczema						
Food allergies						
Sinusitis						
Recurrent sinus or lung infection						
Smoker						
Other significant illnesses						
Living						
Deceased						

Social History

❒Smoke(d), or ❒Nonsmoker ❒Passive Smoke Exposure ❒Occasional Exercise, or ❒Regular Exercise

At what age did you start smoking? ___________; How many cigarettes per day?____________

At what age did you quit smoking? ____________;

❒Caffeine, ❒Recreational Drug

Review of Systems

General
❒fatigue
❒fever/chills
❒unintentional weight loss or gain
❒night sweats

Skin
❒itchiness
❒dryness
❒ulcers
❒discoloration
❒hives
❒swelling
❒excessive hair loss

Eyes
❒dryness
❒vision loss or change
❒tearing
❒itchiness
❒pain
❒red
❒discharge

Ears
❒itchiness
❒ear wax
❒loss or change in hearing
❒ringing
❒fullness/pressure
❒popping
❒loss of balance/dizzy

Pulmonary
❒shortness of breath
❒wheezing
❒coughing (dry/wet)
❒nighttime coughing
❒chest tightness
❒exercise induced shortness of breath

Cardiovascular
❒palpitations
❒irregular heart beat
❒chest pain and pressure

Head/Nose/Throat
❒headache/migraine
❒dizziness/vertigo
❒sore throat
❒hoarseness of voice
❒frequent throat clearing/post nasal drip
❒nasal discharge
❒nasal congestion
❒frequent nose bleeding
❒sinus pain/pressure
❒oral ulcers
❒thrush

Gastrointestinal
❒heartburn or reflux
❒nausea/vomiting
❒diarrhea
❒constipation
❒abdominal pain/bloating
❒bloody stool
❒difficulty swallowing/choking

Hematological
❒anemia
❒enlarged lymph nodes
❒easy bruising and bleeding

Hematologic/Lymph
❒easy bleeding
❒easy bruising
❒enlarged lymph nodes

Musculoskeletal
❒muscle pain
❒joint pain
❒swelling of legs
❒fractures
❒osteoporosis

Neurologic/ psychiatric
❒depression
❒anxiety
❒fainting/syncope
❒stroke
❒seizures

Urinary
❒trouble urinating
❒blood in urine
❒painful urination
❒genital discharge

Current Allergy / Asthma Medication Name	Dose	Frequency
Current Medications for Other Conditions, include Vitamins and Supplements	**Dose**	**Frequency**
List All Medication Allergies:		

IMMUNIZATIONS:____

❒Influenza ____________year
❒TDAP _____________year
❒Shingrix (Shingles) ________year
❒ Pneumovax ________year
❒Hepatitis A ________year
❒Zostavax (Shingles) ________year
❒Prevnar _____________year
❒Hepatitis B ________year

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Patient Copy

NOTICE OF PRIVACY PRACTICES

Updated 9/17/2013

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, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured 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.

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A. How This Medical Practice May Use or Disclose Your Health Information
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 that 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, or following your death.

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 for payment. 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 and their subcontractors 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.

4. 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.

5. 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.

6. Marketing. Generally speaking, the only time a physician may tell a patient about a third-party's product or service without the patient's written authorization is when: 1) the physician receives no compensation for the communication; 2) the communication is face-to-face; 3) the communication involves a drug or biologic the patient is currently being prescribed and the payment is limited to reasonable reimbursement of the costs of the communication (no profit); 4) the communication involves general health promotion, rather than the promotion of a specific product or service; or 5) the communication involves government or government-sponsored programs. Physicians are also still permitted to give patients promotional gifts of nominal value (e.g., pamphlet).

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. 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.

15. 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 agree to the disclosure on behalf of yourself or your dependent.

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. Disclosures to health plans – At the patient's written request, physicians may not disclose information about care the patient has paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law.

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. **Please request a Medical Release Form to complete**. We will also send a copy to any other 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.

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), (notification and communication with family) and (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.

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. [*For practices with websites add*: 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. The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdg. You will not be penalized in any way for filing a complaint.