Dr. Alan Nili, D.O.

Welcome to our practice!

18 Endeavor, Suite 307
Irvine, CA 92618
Phone: (949) 260-0106
Fax: (949) 260-0105

Office Hours: 8:30 a.m. to 5:00 pm Mon- Fri
Closed for lunch 12:00 pm to 2:00 pm.

*For urgent issues *after hours*, please call our office to be connected to the doctor's paging service.*

For serious medical emergencies call 911.

Here are our policies. Please read carefully and keep for reference:

Appointments: Please call as soon as possible when an appointment is needed. Bring your insurance card and current medications to all office visits. Co-payment will be collected before seeing the doctor. We will try our best to accommodate urgent, unforeseen medical problems on the same or following day. **A 24-hour advance notice of cancellation is requested. If you do not call to cancel/reschedule, there will be a $35 fee due before your next visit. ** If you are more than 15 mins late, we reserve the right to cancel/reschedule your appointment ****

Initial_____

Test results: Please **allow two weeks** after you have completed your test for us to receive and review the results. Please call if you have not heard from us within 14 days of your test; we will contact you earlier if there are concerning results. If you would like to discuss your results with the doctor, please schedule an appointment. Otherwise you may leave a message and allow 48 hours for the doctor to get back to you.

Initial_____

Refills: Please call your **PHARMACY** and they will fax a refill request directly to us. Do not wait until you have run out of medication to request a refill. If you prefer to call our office, call during our regular office hours and **allow 48 hours for processing**.

Initial_____

Forms: An appointment should be made if you have forms that need to be filled out by the doctor. These include but are not limited to: physical assessments for school/work, medical status forms, disability forms, time off/excuse forms, etc. You will be charged a co-payment (if applicable). For forms without an office visit, there will be a $25 administrative fee. Allow at least 72 hours for processing. We will contact you when they have been signed.

Initial_____

The doctor will advocate regular health screenings (physical exam, immunizations, colonoscopy, mammogram etc). In addition, he may recommend medication, referral to specialists, additional tests or office visits to appropriately address your medical issues. Please inform him if you do not follow his recommendations. **We reserve the right to discontinue services if you repeatedly fail to follow the doctor's order in treating your medical conditions**

Initial_____

Please ask if you have any concerns or questions. We look forward to becoming your partner in health and will work to provide you with the best medical care possible. Thank you for your cooperation.

Name: _____ **E-mail:** _____

Patient Signature:_____ **Date:** _____

Reviewed by Staff :_____ Date: _____

Date:_____

New Patient Information
(Please Print Legibly)

Name	Sex	Marital Status	Date of Birth	Social Security Number

Home Address	Cell Phone Number	Home Phone Number

City	State	Zip Code	Drug Allergies

Patient's Employer	Occupation	Business Phone Number

Employer's Address	City, State	Zip Code

Spouse or Parent Name	Spouse /Parent Phone Number	Date of Birth

Spouse's or Parent's Employer	Address	City, State, and Zip

Who referred you to us? _____

In case of an emergency, person to notify (Not living at the same address)

Name:_____ Relationship: _____ Phone: _____

Person Responsible for Payment	Street Address, City, State, and Zip	Home Phone Number

Social Security Number	Date of Birth	Employer	Employer Address

Insurance Company	Policy Number	Group Number	Effective Date

Primary Care Physician

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

I hereby authorize Alan Nili, D.O. Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature _____ Date _____

HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

HISTORY OF PAST ILLNESS/INJURIES (HAVE YOU HAD? CHECK ALL THAT APPLY):

Measles/Mumps	☐	Seizure	☐	Peptic Ulcer	☐	Skin Disorder	☐
Allergies	☐	Heart Disease	☐	Kidney Disease	☐	Arthritis	☐
Chicken Pox	☐	Hypertension	☐	Diabetes	☐	Back Pain	☐
Polio	☐	Tuberculosis	☐	Thyroid Disease	☐	Epilepsy	☐
Rheumatic Fever	☐	Pneumonia	☐	STD	☐	Glaucoma	☐
Acid Reflux	☐	Asthma	☐	Anemia	☐	HighCholesterol	☐
Cancer	☐	Hepatitis	☐	Phlebitis/Blood Clot	☐	Joint Disorder	☐
Stroke	☐	Liver Disease	☐	Gout	☐	Lung Disease	☐

Osteoporosis	☐		
Migraines	☐		
Anxiety	☐		
Depression	☐		
Eating Disorder	☐		
Alcoholism	☐		
Substance Abuse	☐		
Other	_____		

Past Surgical History: Any other significant illnesses, injuries, or hospitalizations:

Year _____ Illness _____ Year _____ Surgery _____

Year _____ Illness _____ Year _____ Surgery _____

Year _____ Illness _____ Year _____ Surgery _____

SOCIAL HISTORY: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

FAMILY HISTORY	IF LIVING: AGE	IF LIVING: HEALTH	IF DECEASED: AGE	IF DECEASED: CAUSE
FATHER				
MOTHER				
BROTHER				
SISTER				
HUSBAND / WIFE				
SON / DAUGHTER				

HAS ANY BLOOD RELATIVE EVER HAD:	YES	NO
CANCER -TYPE:		
TUBERCULOSIS		
DIABETES		
HEART TROUBLE		
HIGH BLOOD PRESSURE		
STROKE		
CONVULSIONS		
SUICIDE OR SEVERE DEPRESSION		
MENTAL ILLNESS		
BLEEDING TENDENCY		
GOUT OR OTHER ARTHRITIS		
ALCOHOL OR DRUG PROBLEMS		

	YES	NO
DO YOU LIVE ALONE	☐	☐
DO YOU HAVE DEPENDENTS AT HOME	☐	☐

	YES	NO
HAVE PEOPLE EVER ANNOYED YOU BY CRITICIZING YOUR DRINKING	☐	☐

DO YOU **EXERCISE** REGULARLY : _____ TIMES A WEEK... ☐ ☐

DO YOU **SMOKE** :.....CURRENT ☐..... FORMER ☐..... NEVER ☐

HOW MUCH _____ HOW MANY YEARS _____

DO YOU **DRINK ALCOHOL** ☐ ☐

HOW OFTEN DO YOU DRINK: _____ TIMES PER _____

DO YOU WEAR GLASSES/CONTACTS.....YES ☐ NO ☐

ARE YOU CURRENTLY EMPLOYED:

☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED

WHAT IS YOUR JOB? _____

YEARS OF EDUCATION COMPLETED: _____

HOW MUCH *WORK TIME* HAVE YOU LOST DUE TO YOUR HEALTH WITHIN THE PAST 6 MONTHS _____

MEDICATIONS: ARE YOU TAKING ANY MEDICATIONS or VITAMINS **YES** ☐ **NO** ☐

PLEASE LIST ALL MEDICATIONS INCLUDING SUPPLEMENTS

_____ _____ _____ _____

_____ _____ _____ _____

cont'd please see back--→

Review of Systems

GENERAL
- ☐ CHILLS
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ FEVER
- ☐ HAIR LOSS
- ☐ HAIR GROWTH (EXCESS)
- ☐ NIGHT SWEATS
- ☐ SLEEPING PROBLEMS
- ☐ THIRST (EXCESS)
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

MENTAL HEALTH
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ LOSS OF INTEREST
- ☐ FEELING HOPELESS
- ☐ HEARING VOICES
- ☐ MARITAL PROBLEMS
- ☐ PANIC ATTACK
- ☐ TROUBLE CONCENTRATING
- ☐ SUICIDE (THOUGHT/ATTEMPS)

SKIN
- ☐ ACNE
- ☐ BRUISE EASILY
- ☐ CHANGES IN MOLES
- ☐ CHILLS
- ☐ DRY/ SENSITIVE SKIN
- ☐ ECZEMA
- ☐ HIVES
- ☐ RASH
- ☐ SCARS
- ☐ SORES THAT WON'T HEAL

GASTROINTESTINAL
- ☐ APPETITE GAIN
- ☐ APPETITE LOSS
- ☐ BLOATING
- ☐ BOWEL CHANGES
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ GAS
- ☐ HEMORRHOIDS
- ☐ INDIGESTION
- ☐ INTESTINAL DISORDER
- ☐ LACTOSE INTOLERANCE
- ☐ NAUSEA
- ☐ RECTAL BLEEDING
- ☐ STOMACH PAIN
- ☐ VOMITING
- ☐ VOMITING BLOOD

GENITOURINARY
- ☐ BLOOD IN URINE
- ☐ LACK OF BLADDER CONTROL
- ☐ FREQUENT URINATION
- ☐ PAINFUL URINATION

RESPIRATORY
- ☐ COUGHING
- ☐ COUGHING BLOOD
- ☐ SHORTNESS OF BREATH
- ☐ WHEEZING

CARDIOVASCULAR
- ☐ CHEST PAINS
- ☐ IRREGULAR HEATH BEAT
- ☐ RAPID HEATH BEAT
- ☐ SWELLING OF ANKLES
- ☐ VARICOSE VEINS
- ☐ CIRCULATION PROBLEMS

NEUROLOGICAL
- ☐ COORDINATION PROBLEM
- ☐ CONVULSION
- ☐ DIFFICULTY WALKING
- ☐ LEARNING DISABILITY
- ☐ LIGHT-HEADEDNESS
- ☐ MEMORY LOSS
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ SEIZURE
- ☐ SPEECH PROBLEMS
- ☐ TREMORS
- ☐ PARALYSIS

WOMEN ONLY
- ☐ ANORMAL PAP SMEAR
- ☐ BLEEDING B/W PERIODS
- ☐ BREAST LUMP
- ☐ EXTREME MENSTRUAL PAIN
- ☐ HOT FLASHES
- ☐ NIPPLE DISCHARGE
- ☐ PAINFUL INTERCOURSE
- ☐ VAGINAL DISCHARGE
- ☐ **AGE PERIOD STARTED** _____
- ☐ # OF PREGNANCIES _____
- ☐ # MISCARRIAGES/ ABORTION _____
- ☐ **LAST PAP SMEAR** MM/YY_____
- ☐ **LAST MAMMOGRAM** MM/YY_____

EAR/NOSE/THROAT
- ☐ BLEEDING GUMS
- ☐ BLURRED VISION
- ☐ CROSSED EYES
- ☐ DIFFICULTY SWALLOWING
- ☐ DOUBLE VISION
- ☐ EAR ACHE
- ☐ EAR DISCHARGE
- ☐ HAY FEVER
- ☐ HOARSENESS
- ☐ HEARING LOSS
- ☐ NOSE-BLEEDS
- ☐ PERSISTENT COUGH
- ☐ RECURRING SORE THROAT
- ☐ RINGING IN EARS
- ☐ SINUS PROBLEM
- ☐ VISION HALOS

MUSCULOSKELETAL
- ☐ BACK PAIN
- ☐ CARPEL TUNNEL SYNDROME
- ☐ JOINT PAIN
- ☐ JOINT SWELLING
- ☐ NECK PAIN
- ☐ SHOULDER PAIN

MEN ONLY
- ☐ ERECTILE DIFFICULTIES
- ☐ TESTICULAR LUMP
- ☐ PENILE DISCHARGE
- ☐ SORE ON PENIS

PLEASE LIST ALL KNOWN ALLERGIES (DRUGS, FOOD, ANIMALS, ETC): ☐ NONE

☐ ASPIRIN	☐ CODEIN	☐ IODINE	☐ SOY	☐ DAIRY	☐ SHELLFISH
☐ PENICILLIN	☐ IBUROFEN	☐ LATEX	☐ EGG	☐ GLUTEN	
☐ SULFA	☐ AUGMENTIN	☐ TETRACYCLINE	☐ OTHER:_____		

PATIENT DEMOGRAPHIC

- ☐ .....Asian
- ☐ .....Caucasian
- ☐ .....Hispanic
- ☐ .....Indian
- ☐ .....Black/ African American
- ☐ .....Other: _____

ETHNICITY:
- ☐ OTHER
- ☐ Hispanic
- ☐ Latino
- ☐ Unknown
- ☐ Decline

LANGUAGE:
- ☐ English
- ☐ Farsi
- ☐ Spanish
- ☐ Other: _____

SIGNATURE OF PATIENT: _____ **DATE**_____

QUESTIONNAIRE REVIEWED BY: _____ **DATE**_____

(MEDICAL PROVIDER)

ALAN R. NILI, D.O. Inc.
18 Endeavor, Suite 307
Irvine, CA 92618
Phone (949)260-0106
Fax (949)999-8103

Billing Policy

CO-PAYMENT AND/OR DEDUCTIBLE BALANCES WILL BE COLLECTED AT THE TIME OF SERVICE.

Your insurance may not pay for everything, even some care that your health care provider deems necessary. I, the patient, understand that if my insurance does not pay, I, the patient, am responsible for payment.

Initial_____

We will bill your insurance company as a courtesy to you. However, we are not responsible for following up with the insurance company to ensure that they provide reimbursement. This is your responsibility.

Patients with HMO/Managed Care insurance plans will need to provide Proof of eligibility at the time of service.

Payment arrangements can be made in advance of services rendered in case involving cash patients and/or financial hardships.

We apologize for any inconvenience this policy may cause. However, we are always available to work with you in resolving any problems.

I have read and understand the above information and I agree to comply accordingly.

_____ _____
Signature of Patient/Guardian **Date**

_____
Printed Name

SEE BACK SIDE →

ALAN NILI D.O.

Family Practice
Diplomate of American Board of Family Practice

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 you have the right to request that communications concerning your personal health information be made through confidential channels. Dr. Nili's office will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. ***Some method of contact must be provided****, and as appropriate, information as to how payment will be handled.*

I, _____, give my permission to Dr. Nili's office to communicate
(Print Name of Patient)
information related to my personal health, as indicated below. *This request supersedes any prior request for communication of information I may have made.*

Phone Contact:

You ☐ May ☐ May Not contact me regarding my appointments by telephone.

You ☐ May ☐ May Not contact me regarding my test results by telephone.

You ☐ May ☐ May Not contact me regarding my condition and treatment by phone.

You may use the following telephone numbers:

☐ Cell (_____) _____ You ☐ May ☐ May Not leave messages on voice mail.

☐ Home (_____) _____ You ☐ May ☐ May Not leave messages on voice mail.

☐ Work (_____) _____ You ☐ May ☐ May Not leave messages on voice mail.

My **preferred** contact phone number is:

Cell Phone □ Home Phone □ □ Other: (_____) _____

☐ You may leave messages and discuss my medical history with the following people (*Print Names*):

_____ Relation:_____

_____ Relation:_____

Mail

☐ Send mail regarding appointments, my test results or my condition and treatment to the following address:

_____

_____

E-Mail Address

_____

Signature: _____ Date:_____
(Parent or Legal Guardian if Patient is a Minor)

Name: _____ Relationship: _____

ALAN NILI D.O.

Family Practice

Diplomate of American Board of Family Practice

ACKNOWLEDGEMENT OF RECIEPT

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Alan R. Nili D.O. Incorporated. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change.

I acknowledge receipt of the *Notice of Privacy Practices* of Alan R. Nili D.O. Incorporated.

Signature: _____ Date: _____

(patient / parent / guardian / conservator)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained.

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Signature of Provider Representative: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Dr Alan Nili D.O.
18 Endeavor Suite 307
Irvine, CA 92618
Phone (949) 260-0106

Effective Date: _____

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. ***[Participants in organized health care arrangements only should add: 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. **[Optional: <u>Appointment Reminders</u>**. 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. **<u>Sign In Sheet</u>.** 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. **<u>Notification and Communication with Family</u>**. 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. **<u>Marketing</u>**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,

   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future

remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. **[Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.] [*Add the following three activities, or any of the three, only if the organization engages or intends to engage in these activities*.]**
22. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. **Fundraising**. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

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

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

C. Your Health Information Rights

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

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

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

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

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

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

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

D. Changes to this Notice of Privacy Practices
We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.
After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. **[*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.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.