Los Alamitos Family Health & Wellness
Dr. Jennifer Kim Loomis
3851 Katella Ave Suite 275
Los Alamitos, CA 90720

WELCOME, please tell us about yourself. **Referred by:**

Last Name: _____ Suffix: _____ First Name: _____

Middle Name: _____ Nickname: _____

Address: _____ Apt: _____ City: _____

State: _____ Zip: _____

Phones Home: _____ Work: _____

Cell: _____ Fax: _____

Preferred Number: _____E-Mail Address:_____

How do you want to receive messages and test results:_____

Date of Birth: _____ Gender: _____ Marital Status: _____

Social Security Number: _____

Spouse Name: _____ Phone: _____

Spouse Birth Date: _____ Alternate Phone: _____

Who can we contact in case of an emergency? (If it is the same as your spouse you can leave this blank):

_____ What is their relationship to you?: _____

Phone: _____ Alternative Phone: _____

Are you employed?: _____ Where?: _____

Address: _____

We have the ability to transmit prescriptions to your pharmacy electronically if they participate in E RX.

What is your pharmacy name?: _____ Phone: _____

Is this a mail order pharmacy?: _____ Did they give you a fax form?: _____

Please tell us about your insurance, if you have given the receptionist your insurance card/s you can leave this part blank.

Primary Insurance: _____ ID #: _____ Group #: _____

Customer Service Phone: _____ Authorization phone: _____

Claim Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Customer Service Phone: _____ Authorization phone: _____

Claim Address: _____

Subscriber Name (if other than patient): _____ DOB: _____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plan to Los Alamitos Family Health and Wellness.

This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including but not limited to co-payments and annual deductibles. I hereby authorize said assignee to release all information to secure the payment. I hereby consent to and authorize all treatment and medical services by the physician and staff of this office, as they deem necessary. I authorize the release of any information regarding my history, treatment, findings, X-ray findings and other clinical studies and diagnosis that this office deems necessary.

Signed: _____ Date: _____

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(562) 296-5528

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature Date Physician Signature

YOUR NAME:_____

FAMILY PRACTICE/INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

_____

Other concerns:

_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY REACTION

1._____
2._____
3._____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins, NSAIDs and inhalers.

DRUG NAME STRENGTH FREQUENCY TAKEN

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

IMMUNIZATION HISTORY

- ☐ Chickenpox Date:_____
- ☐ Flu Shot Date:_____
- ☐ Gardasil/HPV Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ Meningococcus Date:_____

Immunizations and most recent date:

- ☐ MMR (*Measles, Mumps, Rubella)* Date:_____
- ☐ Pneumonia Date:_____
- ☐ Tdap (*Tetanus and pertussis)* Date:_____
- ☐ Tetanus Date:_____
- ☐ Zostavax (*Shingles)* Date:_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____

- ☐ Cesarean sections If yes, then number: _____
- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active

Current sexual partner is ☐ Female ☐ Male
Do you use condoms? ☐ Yes ☐ No
Other Birth control method used:_____

- ☐ Interested in being screened for STD's

PAST MEDICAL HISTORY **Please check all that apply:**

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other (please explain below)

_____

_____

PAST SURGICAL HISTORY

SURGERY	**REASON**	**YEAR**
1.		
2.		
3.		
4.		

ANY HOSPITAL OR ER VISITS?_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS SUCH AS **DEPRESSION, CANCER, DIABETES, HEART DISEASE, OSTEOPOROSIS, STROKE**
Grandmother (maternal)	Y/N	____	_____
Grandfather (maternal)	Y/N	____	_____
Grandmother (paternal)	Y/N	____	_____
Grandfather (paternal)	Y/N	____	_____
Father	Y/N	____	_____
Mother	Y/N	____	_____
Brother/Sister	Y/N	____	_____
Brother/Sister	Y/N	____	_____
Other:_____	Y/N	____	_____

SOCIAL HISTORY

OCCUPATION_____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level ☐ None (No exercise) ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

# of cups/cans per day? _____

Alcohol Do you drink alcohol? ☐ Yes ☐ No

If so, how often? ☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week

How many drinks per week? __

Tobacco Do you use tobacco? ☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No

☐ Cigarettes - _____pks./day ☐ Chew - _____/day ☐ Cigars - _____/day ☐ # of years_____

Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No

If yes, list:

_____

_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest heaviness/ Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/ Hunger/Urination
- ☐ Difficulty getting pregnant

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam: _____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent colds/sinus infections
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control
- ☐ Erectile dysfunction

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands
- ☐ Anemia

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Fracture Type_____
- ☐ Fall or imbalance
- ☐ Use of assist device

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems
- ☐ History of addiction

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

Patient, Parent, or Guardian Signature:_____

Date:_____

LOS ALAMITOS FAMILY HEALTH AND WELLNESS
DR JENNIFER KIM-LOOMIS
3851 KATELLA AVE SUITE 275
LOS ALAMITOS CA 90720
(562) 296-5528 (562) 296-8506

Laboratory Services Notice

In managing your health it is sometimes required to do certain laboratory testing. Although we do some testing here in our office we sometimes need to send your laboratory testing to an outside laboratory.

We use several laboratories depending on the type of testing required. They include Quest Diagnostics, Labcorp, Atherotech Laboratory, Genova Diagnostics, and Pathology Inc as our Reference Laboratories.

We are not affiliated with these laboratories in any way and Dr. Kim-Loomis has chosen these laboratories based on her confidence in the quality of their testing and the testing offered by them.

While these laboratories take most insurances your insurance may require you to utilize another laboratory. **Using one of these laboratories may result in a higher out of pocket cost to you.** We do not know what your insurance requirements are. We suggest you call your insurance if you are unsure whether these laboratories are preferred providers with your individual insurance.

If you want your lab work to be sent to a specific laboratory you must let us know, please fill out the bottom of this notice and return to us, we will note it in your chart but we do ask you to also let Dr. Kim-Loomis know every time testing is ordered. If you do not specify a certain laboratory, your lab work will be sent to one of the above laboratories.

I have read and understand Dr. Kim Loomis' Laboratory Services Notice.

Signed: _____

Date: _____

I want my testing to go to a specific laboratory. The laboratory I want used is _____. **I again acknowledge that I understand LAFHW does NOT know what laboratory may or may not be covered on my insurance plan**. I understand that if you don't have a courier to transport my specimen to this laboratory I may need to go to their draw station with written orders for testing. This request will remain in effect until and unless I notify you in writing of any change.

Signed:_____

Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. We ask that on these occasions you give us at least 24 hours notice (48 hours for Saturday appointments). It is our policy to charge a $20 fee ($40 for Saturday) if not cancelled within the above time frames. Please note this is an administrative fee and therefore will not be covered by your insurance.

I have read and understand Dr. Kim-Loomis' Cancellation Policy.

Signed: _____

Date: _____

PF 5000

AUTHORIZATION TO COMMUNICATE PATIENT'S MEDICAL INFORMATION

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

(Signed original to be placed in the central medical record and copy to patient)

PATIENT IDENTIFICATION

Name:_____

Date of birth:_____

S.S. #:_____

Medical Record/Account#:_____

Office Name:_____

Address:_____

City/State/Zip:_____

Phone number:_____

Fax number:_____

Physician name:_____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance

Specific instructions or limitations:_____

_____

Validation code: _____ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/Legal Representative:_____ Date:_____

Relationship to patient:_____

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(562) 296-5528

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY

Effective January 1, 2012

The following is the privacy policy ("Privacy Policy") of Los Alamitos Family Health and Wellness ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review

activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Los Alamitos Family Health and Wellness 3851 Katella Ave Suite 275 Los Alamitos CA 90720.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Los Alamitos Family Health and Wellness 3801 Katella Ave Suite 222 Los Alamitos CA 90720.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Darla Long at Los Alamitos Family Health and Wellness 3801 Katella Ave Suite 222 Los Alamitos CA 90720 phone (562) 296-5528 fax (562) 249-7967. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or

changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Los Alamitos Family Health and Wellness 3851 Katella Ave Suite 275 Los Alamitos CA 90720 or at the following website address: Losalfamilyhealth.com. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer Darla Long at the address, telephone number, or e-mail address listed above.

Acknowledgement of Receipt of Notice of Privacy Practices
The Practice reserves the right to modify the privacy practices outlined in this notice

I have received a copy of the Notice of Privacy Practices.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Representative