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NEW PATIENT REGISTRATION FORM

PHYSICIAN: **Eileen Chan, M.D.** ☐ **Niki Saxena, M.D.** ☐ **Laura Chiang, M.D.** ☐ **Leslie Sue, D.O.** ☐

PATIENT INFORMATION **Today's Date:** _____

Name: Last	First	M.I.	Date of Birth	Social Security Number
Street Address		City	State	Zip Code
M/F	Home Phone		Hospital of Birth	
Sibling Name			Date of Birth	M/F
Sibling Name			Date of Birth	M/F
Sibling Name			Date of Birth	M/F

PARENT #1 INFORMATION ☐ **Lives with this parent** ☐ **Send Billing to this parent**

Name: Last	First	M.I.	Male/Female	Date of Birth	Social Security Number
Street Address (If different from child)			City	State	Zip Code
Home Phone		Cell Phone		E-Mail Address	
Employer/Occupation				Employer Phone Number	

PARENT #2 INFORMATION ☐ **Lives with this parent** ☐ **Send Billing to this parent**

Name: Last	First	M.I.	Male/Female	Date of Birth	Social Security Number
Street Address (If different from child)			City	State	Zip Code
Home Phone		Cell Phone		E-Mail Address	
Employer/Occupation				Employer Phone Number	

EMERGENCY CONTACT INFORMATION

Name	Relationship	Daytime Phone Number
Name	Relationship	Daytime Phone Number

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Redwood City, CA 94063
650-216-7794

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INSURANCE INFORMATION

GUARANTOR/INSURANCE POLICY HOLDER

Name: Last	First	Date of Birth
Relationship to Patient		Social Security Number

INSURANCE INFORMATION

Name of Company:		
P.O. Box/ Address:		
City:	State:	Zip Code:
Policy Number:		Group Number:
Effective Date:		Employer:

CONSENT

CONSENT TO RELEASE:
I hereby authorize the physicians of Pediatric Wellness Group to release any and all (including dental) information to the above named insurance carrier (or to a designated attorney) for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until it is revoked in writing.

CONSENT TO ASSIGNMENT:
I hereby assign payment of medical service to Pediatric Wellness Group to which I am entitled or have incurred for medical and/or surgical services rendered here. I understand I am financially responsible to said group for charges not covered by this assignment. I further agree in the event of nonpayment to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

CONSENT TO TREAT:
I authorize Pediatric Wellness Group to which to provide medical care to my child and authorize treatment or care in my absence if my child is accompanied by the following care giver (check all that apply):

Grandparent(s)/Sibling:_____ Nanny/Babysitter:_____ Other: _____

PLEASE NOTE: Unless accompanied by a note from a guardian, vaccinations will NOT be administered to minors.

Signature of Parent/Legal Guardian: _____ Date: _____

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Patient Name:_____

Patient's Ethnicity:

Please circle the appropriate answer

Hispanic or Latino

Not Hispanic or Latino

Prefers not to answer

Patient's Race:

Please circle the appropriate answer

Am. Indian / AK Native

Asian

Black or African American

Native HI / Pacific IS

Prefers not to answer

White

Preferred Language:_____

Contact e-mail for confidential Communication / appointment reminders

_____

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PATIENT'S FAMILY MEDICAL HISTORY

Do any of the child's immediate family members - grandparents, parents, aunts/uncles, siblings - have the following or have had a history of any of the following conditions?

Please check ✓ all that apply

Patient:_____

CONDITION	DON'T KNOW	NO	YES	FAMILY MEMBER
CHRONIC EAR INFECTION				
ALLERGIES: ENVIROMENTAL				
ALLERGIES: MEDICATION				
ASTHMA				
ADHD				
DEPRESSION				
ANXIETY				
LEARNING/DEVELOPMENTAL DISABILITIES				
HEART DISEASE/HEART MURMURS				
HIGH CHOLESTEROL				
KIDNEY DISEASE				
BLOOD DISORDERS(example: leukemia)				
DIABETES				
HIGH BLOOD PRESSURE				
THYROID DISEASE				
SEIZURES				
CANCER:				
SMOKING				
ALCOHOL/DRUG USE				
OTHER:				

Were you referred to our group? ☐ Y ☐ N

If so, by whom? _____

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FINANCIAL POLICY

Upon registration: Please provide the following information & items: insurance card (if you are a member of one of the plans that we participate with), the name, date of birth, social security number and address of the person who is the plan member; photo ID, address, patient's date of birth and social security number, contact phone numbers of both parents and/or all guardians.

Health Insurance Cards: When scheduling each appointment, our team will verify your insurance information with you. Eligibility will be verified prior to or upon check-in at each appointment. Please make sure you bring your card to every appointment, and if your insurance changes, please notify us as soon as possible.

Health Insurance Plans: We participate with many different plans and simply cannot know the provisions of every patient's policy. We strongly recommend that you make every effort to understand your insurance coverage & if necessary contact your carrier prior to receiving services in order to verify your coverage levels (such as coverage for preventive care) and copay, deductible and coinsurance responsibilities.

Copayments: It is our contractual responsibility to collect your copayment at the time of your visit and it is your responsibility to pay your copayment amount at the time of your appointment. Please have your payment ready upon check-in. If you do not pay your copayment at the time of service, there will be a fee of $10 in addition to the co-pay amount per billing cycle.

Missed Appointments: Life happens and we understand that sometimes you cannot make your appointment. Please call us at least one day in advance to cancel or change your scheduled appointment. No call to our office equals a 'No Show' and we reserve the right to charge a $50 fee to cover some of the cost of that unfilled appointment slot.

Balances and deductibles: It is our responsibility, as detailed by the terms of our contracts with the health insurance companies that we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns as your responsibility. It is your responsibility to pay this portion of your bill. If you do not remit full payment (or call us to set up a payment plan) on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections and subject to collection fees. If you are having difficulty meeting medical bills, please let us know and we will be happy to help you by setting up a payment plan. There will be a $10.00 convenience fee added each month for accounts on payment plans, subject to change. We encourage you to contact our billing office via phone at (650) 288-0600 option 7, or via email at billing@pwgrwc.com, with any questions or concerns. Failure to address your financial obligations with us may result in dismissal from our practice.

Returned Checks: If your payment by check is returned by the bank for insufficient funds (NSF), you will remain responsible for the amount of the check plus an additional fee of $35. If more than one check is returned in any given period, we reserve the right to require all future payment by credit card or cash to prevent this situation from recurring.

Forms: The cost of researching, filling out and signing forms is not covered by health insurance. . We charge a nominal $5 fee to cover the costs of completing these forms and require four (4) business days to fill them out. For forms that need to be filled out on the same day there will be a $30.00 charge. These fees may change time-to-time.

Health insurance non-payment: We cannot carry open claims for more than 90 days, except in the most extenuating circumstances. For the plans in which we participate, services that have not been paid for by your health insurance carrier within 90 days of claim submission will be billed to you (without an invoice charge) and become your responsibility to pay in full. Should your health insurance carrier later pay us for those services, we will immediately reimburse you.

Guarantor: The parent or guardian who signs the patient's paperwork is the party responsible for all charges and payments. Due to confidentiality rules we can only bill the person who signs the practice paperwork; therefore, if the person responsible for the medical bill changes, the new guarantor must complete a new set of paperwork. Please inform us as soon as circumstances change.

Self-pay patients: If you do not have health insurance, if we are out-of-network for your insurance plan, or if you are receiving a non-covered service, payment at the time of the visit is required. We are happy to provide you with a bill after your visit is complete. You can submit this to your insurance plan, or keep for your records.

Divorce and Separation Decrees: Pediatric Wellness Group is not a party in divorce or separation decrees or in child support arrangements. We bill one guarantor, at one address, and expect prompt payment. We do not handle billing or insurance coverage disputes between parents.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to PWG for any services furnished to my dependent or ward. I acknowledge that I am financially responsible for the accuracy of all information provided.

Parent/ Guardian Signature: _____ Date: _____

Parent/ Guardian name (Print): _____ Relationship to patient: _____

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A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

Sincerely,

Pediatric Wellness Group

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**

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 rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**

It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service 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. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil ProcedureSections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**

All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**

This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**

If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____

Patient's or Patient Representative's Intials

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.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have made or received a copy.

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.

By: _____ _____/_____/_____
Physician's or Authorized Representative's Signature Date
Print or Stamp Name of Physician, Medical Group, or Association Name

Print Patient's Name _____

By: _____ _____/_____/_____
Patient's or Patient Representative's Signature Date
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient.
Original is to be filed in Patient's medical records.

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Lorie Thomas, Privacy Officer

PRIVACY POLICY STATEMENT

Purpose: *The following privacy policy is adopted to ensure that this medical practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.*

Effective Date: *This policy is in effect as of May 2, 2011.*

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California law.

Notice of Privacy Practices

It is the policy of this medical practice that a notice of privacy practices must be published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this medical practice to post the most current notice of privacy practices in our "waiting room" area, and to have copies available for distribution at our reception desk.

Assigning Privacy and Security Responsibilities

It is the policy of this medical practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rule's requirements. Furthermore, it is the policy of this medical practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this medical practice that there will be one individual or job description designated as the Privacy Official.

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Deceased Individuals

It is the policy of this medical practice that privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information

It is the policy of this medical practice that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance such uses and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this medical practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

Marketing Activities

It is the policy of this medical practice that any uses or disclosures of protected health information for marketing activities will be done only after a valid authorization is in effect. It is the policy of this organization to consider marketing any communication intended to induce the purchase or use of a product or service where an arrangement exists in exchange for direct or indirect remuneration, or where this organization encourages purchase or use of a product or service directly to patients. This organization does not consider the communication of alternate forms of treatment, or the use of products and services in treatment, or a face-to-face communication made by us to the patient, or a promotional gift of nominal value given to the patient to be marketing, unless direct or indirect remuneration is received from a third party and the communication is not to a health plan enrollee concerning: 1) a provider's participation in the health plan's network, 2) the extent of covered benefits, or 3) the availability of more cost-effective pharmaceuticals. This organization may make remunerated communications tailored to individual patients with chronic and seriously debilitating or life-threatening conditions for the purpose of educating or advising them about treatment options or maintaining adherence to a prescribed course of treatment, without a signed patient authorization. If we do so, we will disclose in at least 14-point type the fact that the communication is remunerated, the name of the party remunerating us, and the fact the patient may opt out of future remunerated communications by calling a toll-free number. This organization will stop any further remunerated communications within 30 days of receiving an opt-out request.

Mental Health Records

It is the policy to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:

A. Use by originator for treatment;

B. Use for training physicians or other mental health professionals as authorized by the regulations;

C. Use or disclosure in defense of a legal action brought by the individual whose records are in issue;

D. Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.

Complaints

It is the policy of this medical practice that all complaints relating to the protection of health information be investigated and resolved in a timely fashion. Furthermore, it is the policy of this medical practice that all complaints will be addressed to Dr. Niki Saxena who is duly authorized to investigate complaints and implement resolutions if the complaint stems from a valid area of non-compliance with the HIPAA Privacy and Security Rule.

Prohibited Activities-No Retaliation or Intimidation

It is the policy of this medical practice that no employee or contractor may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. It is also the policy of this organization that no employee or contractor may condition treatment, payment, enrollment or eligibility for benefits on the provision of an authorization to disclose protected health information except as expressly authorized under the regulations.

Responsibility

It is the policy of this medical practice that the responsibility for designing and implementing procedures to implement this policy lies with the Privacy Official.

Verification of Identity

It is the policy of this medical practice that the identity of all persons who request access to protected health information be verified before such access is granted.

Mitigation

It is the policy of this medical practice that the effects of any unauthorized use or disclosure of protected health information be mitigated to the extent possible.

Safeguards

It is the policy of this medical practice that appropriate physical safeguards will be in place to reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule.

These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this organization.

Business Associates

It is the policy of this medical practice that business associates must be contractually bound to protect health information to the same degree as set forth in this policy. It is also the policy of this organization that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

Training and Awareness

It is the policy of this medical practice that all members of our workforce have been trained by the compliance date on the policies and procedures governing protected health information and how this medical practice complies with the HIPAA Privacy and Security Rules. It is also the policy of this medical practice that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of this medical practice to provide training should any policy or procedure related to the HIPAA Privacy and Security Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is the policy of this medical practice that training will be documented indicating participants, date and subject matter.

Material Change

It is the policy of this medical practice that the term “material change” for the purposes of these policies is any change in our HIPAA compliance activities.

Sanctions

It is the policy of this medical practice that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual’s personnel file.

Retention of Records

It is the policy of this medical practice that the HIPAA Privacy Rule records retention requirement of six years will be strictly adhered to. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Regulatory Currency

It is the policy of this medical practice to remain current in our compliance program with HIPAA regulations.

Cooperation with Privacy Oversight Authorities

It is the policy of this medical practice that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy compliance reviews and investigations.

Investigation and Enforcement

It is the policy of this medical practice that in addition to cooperation with Privacy Oversight Authorities, this medical practice will follow procedures to ensure that investigations are supported internally and that members of our workforce will not be retaliated against for cooperation with any authority. It is our policy to attempt to resolve all investigations and avoid any penalty phase if at all possible.

NOTICE OF PRIVACY PRACTICES
Pediatric Wellness Group
801 Brewster Ave. Suite 175 Redwood City, CA 94063

Lorie Thomas 650-216-7794

Effective Date: Sept 1, 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 and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with

our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. While a complete listing of the OHCAs we participate in is available from the Privacy Official, we want you to know we participate in the Sequoia Quality Care Network (SQCN), a clinically integrated network of physicians and hospitals, governed by physicians, which will share patient information with other healthcare providers, in a secure manner, to achieve improvements in the quality of patient care.

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. 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.

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

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this

medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

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

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

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

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

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

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

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

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

E. Complaints
Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Lorie Thomas, Privacy Officer
801 Brewster Ave., Suite 175, Redwood City, CA 94063
650-216-7794

Acknowledgement of Receipt of Notice of Privacy Practices

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

Signed:_____

Date: _____

Print Name: _____

Telephone: _____

If not signed by the parent, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name of Patient:_____

Patient Address:_____

City, State, Zip:_____