PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
A Professional Corporation

PATIENT INFORMATION - CONFIDENTIAL

Last Name: _____ First Name_____ MI_____
Date of Birth: _____ SS# _____ Sex: Male ☐ Female ☐
Email Address: _____
Address: _____ City _____State:_____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Employer: _____ Occupation: _____
Driver's License #: _____ State: _____ Expires: _____ Marital Status: _____
Referring Physician: _____ Phone: _____
Emergency Contact: _____ Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED

I hereby assign all benefits to Pacific Cardiovascular Associates Medical Group, Inc. for services rendered to me or said patient. I authorize any holder of medical information about me or said patient to release to my Insurance Company any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to Pacific Cardiovascular Associates and I authorize the release of medical information necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures. I understand that I am responsible for all charges not covered by my insurance policy including, but not limited to, co-payments, deductibles and non-covered services. I also agree to pay the "no show" fee if I fail to keep my appointment without adequate advance notice. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if my insurance company does not remit payment on my behalf.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of PCA'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.
☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____

COMMUNICATION CONSENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Please check all that apply):

☐ Preferred Telephone Number _____ ☐ Ok to leave message with detailed information
☐ Secondary Telephone Number _____ ☐ Ok to leave message with detailed information

HIPAA DISCLOSURE INFORMATION

By completing this you are granting permission to someone other than yourself to have access to scheduled appointment times, schedule an appointment and be informed about test results and general information regarding your health.

Disclosure to:
☐ Spouse Name: _____ Initial _____
☐ Children Name: _____ Initial _____
☐ Other Name: _____ Initial _____
Please add any special instructions regarding the release of your medical information (i.e., specific family member or representative): _____

Patient Signature: _____ Date: _____

If not signed by the patient, please indicate relationship:
☐ Parent or guardian or minor patient ☐ Guardian or conservator of an incompetent

PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
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Patient Partnership Plan

Dear Patient,

Welcome to our practice. Ensuring the cardiovascular well-being of our patients and their families has been PCA's mission for over 30 years. We strive every day to provide you with the highest quality of care you expect and deserve. Providing you with the **best possible care** requires a "partnership" between you and your physician. To embark on this "partnership in your health" we ask you to help us and we need your agreement to the following. This is not an exhaustive list but highlights a few key areas.

1. Keep Appointments for Consultation, Follow up or Testing
I understand that the appointments for consultation, follow up or testing are very important to initiate and/or execute my treatment plan. During these appointments, my physician might order tests, review my plan of care, prescribe medication, or even discover and treat a serious health condition. If I don't show up for my appointment, or miss my appointment and fail to reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition.

In addition, I understand that missing or not showing up for my appointment creates a significant hardship for my physician and is not fair for other patients who would like to access cardiology services by my physician's practice. I will make every effort to notify my physician, his or her nurse or the scheduling team a minimal of **48** hours in advance of my appointment cancellation and reschedule missed appointments, as soon as possible.

If you are unable to make your appointment due to a *bona fide* emergency no cancellation fee will apply provided you supply written documentation or proof of the emergency. In all other instances a "**$50.00 no show cancellation fee**" will be charged, without exception, for un-kept appointments not canceled **48** hours before the scheduled appointment time.

2. Contact the Physician's 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. If my contact information has changed I will notify PCA of my updated contact information.

3. Inform My Physician if I Decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my physician may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, ordering tests, performing procedures, referring me to other specialists, ordering lab tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan is my right but can have serious negative effects on my health. I will let my physician 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. We are here to help you get better and lead active healthy lives.

_____ _____
Patient Name (Print) Date

_____
Patients Signature

P · C · A

PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
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Appointment Reminder/ Patient Portal Preferences

Patient Last Name: _____ **Patient First Name:** _____

Patient Date of Birth: _____

1. **Preferred method to be reminded of your appointment: (Only select 1 option)**

   ☐ **Phone** (voice message) Phone Number: _____

   ☐ **Text Message** Cell Number: _____

   ☐ **Email** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

   * **If you select an email appointment reminder, please check your spam file**

2. **Would you like to be enrolled in Patient Portal?**

   ☐ **Yes** ☐ **No**

   (If you did not provide your email above please provide it for Patient Portal)

   Email | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Enrolled by: _____

Patient Signature: _____ **Date**: _____

PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

3080 Bristol Street, Suite 600
Costa Mesa, CA 92626
Fax: (714) 445-0245

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Healthcare Provider's Name and Address

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____
Name

_____
Address City State Zip Code

_____
Fax Email

The medical information/records will be used for the following purpose: _____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Genetic Information _____ (initial)
Tests for Antibodies to HIV _____ (initial)
HIV Diagnosis/Treatment _____ (initial)

DURATION (Not to exceed 2 years)

This authorization shall be effective immediately and remain in effect until _____Date

*If changing physician practice, please explain why: _____

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness Name (Print) Witness Signature

PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
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♥ PATIENT (SELF) CARDIOVASCULAR HEALTH HISTORY ♥
CONFIDENTIAL

Name: _____**Date of Birth**_____
First Last MI

Sex: ☐ Male ☐ Female Present or Retired Occupation: _____Marital Status: _____

Preferred Contact Number: _____

Current Medical Symptoms / Complaints:

_____

_____

List Allergies (Medicines, Foods, Etc.):

_____

_____

Please List all Medications (include dose & how it is taken)

MEDICATION	DOSEAGE	HOW/WHEN TAKEN

PLEASE LIST MEDICAL OPERATIONS AND DATES
1.
2.
3.
4.
5.

FAMILY HISTORY:
If family members are living, list health problems and their ages. If deceased, please give age and cause of death.

MOTHER	**DECEASED**	**SISTERS**	**DECEASED**	**BROTHERS**	**DECEASED**
FATHER	**DECEASED**				

If there are close relatives with a history of heart disease, high cholesterol, high blood pressure, stroke, diabetes, cancer, etc., please indicate their relationship, specific medical condition and their age:

_____

_____

_____

SOCIAL HISTORY:

- **Do you Smoke?** ☐ **Yes** ☐ **No** **If Yes, how much per day?** _____
- **Have you ever smoked?** ☐ **Yes** ☐ **No** **If Yes, for how many years?** _____
- If you stopped smoking, how long ago? _____ What age did you start? _____
- **Do you drink Alcohol?** ☐ **Yes** ☐ **No** **If Yes, how many drinks per week?**_____
- **If you stopped drinking, how long ago?** _____

•Are you currently or have you been a heavy user of prescriptions or non-prescription stimulant drugs?
☐ Yes ☐ No

•If you are exercising, please list the type of exercise, frequency, and duration (e.g., walking 3 times per week for 20 minutes):

_____

•Do you follow a special diet? ☐ **Yes** ☐ **No** ☐ **Low Salt** ☐ **Low Fat** ☐ **Low Cholesterol**
Other: _____

•Are you currently on or have you used prescription or non-prescription weight loss drugs? ☐ Yes ☐ No

III. RISK FACTORS (Please check all that apply):

☐ **Diabetes**	☐ **High Blood Pressure**	☐ **High Cholesterol**	☐ **Overweight**
☐ **Undue Stress**	☐ **Previous Heart Attack**	☐ **Peripheral Vascular Disease**	☐ **Smoking History**
☐ **Post-Menopausal**	☐ **Prior Bypass Surgery**	☐ **History of Stroke**	☐ **Prior Valve Surgery**
☐ **Prior Angioplasty or Stent**			

•If Female, are you still menstruating? ☐ **Yes** ☐ **No**
•Are you Pregnant? ☐ **Yes** ☐ **No**
•If No, do you still use Birth Control? ☐ **Yes** ☐ **No**
Date of Last Chest X-Ray: _____ **Date of Last EKG:** _____

IV. REVIEW OF SYSTEMS:

•Chest Pain at Rest	☐ Yes	☐ No	Date Began: _____
•Chest Pain Exercising	☐ Yes	☐ No	Date Began: _____
•Palpitations (Heart Pounding, Racing)	☐ Yes	☐ No	Date Began: _____
•Short of Breath at Night / Lying Down	☐ Yes	☐ No	Date Began: _____
☐ At Rest	☐ Yes	☐ No	Date Began: _____
☐ Exercising	☐ Yes	☐ No	Date Began: _____
•Calf / Leg Pain with Ambulation	☐ Yes	☐ No	Date Began: _____
•Rheumatic Fever	☐ Yes	☐ No	Date Began: _____
•Rheumatic Heart Disease	☐ Yes	☐ No	Date Began: _____
•Heart Murmur	☐ Yes	☐ No	Date Began: _____
•Swelling of Feet or Ankles (Edema)	☐ Yes	☐ No	Date Began: _____
•Congestive Heart Failure	☐ Yes	☐ No	Date Began: _____
•Dizziness	☐ Yes	☐ No	Date Began: _____
•Fainting	☐ Yes	☐ No	Date Began: _____
•Cough with or without Sputum	☐ Yes	☐ No	Date Began: _____
•Nausea / Vomiting	☐ Yes	☐ No	Date Began: _____
•Bloody or Black Stool	☐ Yes	☐ No	Date Began: _____
•Hepatitis or Jaundice	☐ Yes	☐ No	Date Began: _____
•Easy Bruising or Bleeding	☐ Yes	☐ No	Date Began: _____
•Thyroid Disorder	☐ Yes	☐ No	Date Began: _____
•Lung Disease	☐ Yes	☐ No	Date Began: _____
•Kidney Disease	☐ Yes	☐ No	Date Began: _____
•Headache	☐ Yes	☐ No	Date Began: _____
•Leg Cramping	☐ Yes	☐ No	Date Began: _____
•Neurological disorder	☐ Yes	☐ No	Date Began: _____
•Cancer	☐ Yes	☐ No	Date diagnosed_____ Type_____
•Bleeding disorder	☐ Yes	☐ No	Date Began: _____

Patient Signature: _____ Date: _____

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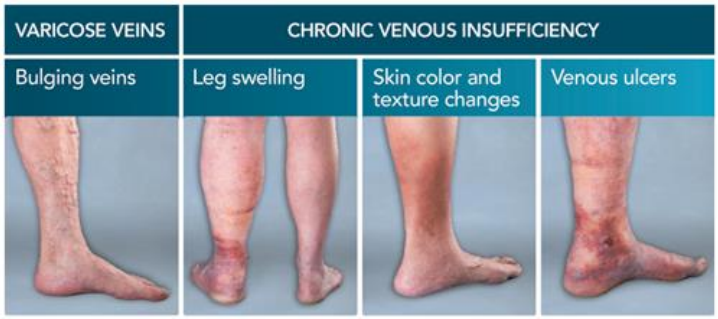
♥Vein Screening & PAD Assessment Form ♥

Patient Name: _____ DOB: _____

Vein Screening – Answer Yes or No / which Leg: Right leg or Left leg?

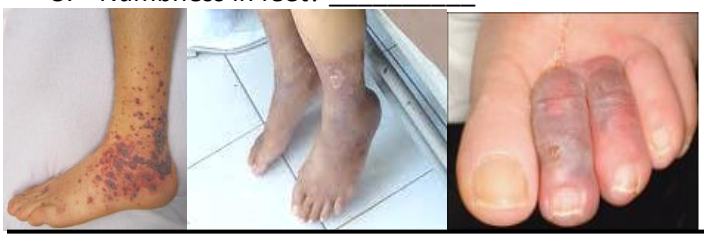
Do you experience any of the following in your leg(s)?

Aching / Pain	❑ Y ❑ N	Leg: ❑ R ❑ L
Heaviness	❑ Y ❑ N	Leg: ❑ R ❑ L
Bulging Varicose veins	❑ Y ❑ N	Leg: ❑ R ❑ L
Tiredness / fatigue	❑ Y ❑ N	Leg: ❑ R ❑ L
Spider Veins & Leg pain	❑ Y ❑ N	Leg: ❑ R ❑ L
Itching / Burning	❑ Y ❑ N	Leg: ❑ R ❑ L
Swelling / Edema	❑ Y ❑ N	Leg: ❑ R ❑ L
Cramps /Throbbing	❑ Y ❑ N	Leg: ❑ R ❑ L
Restless Legs	❑ Y ❑ N	Leg: ❑ R ❑ L
Non-Healing wounds/Ulcers	❑ Y ❑ N	Leg: ❑ R ❑ L



PAD (Peripheral Arterial Disease) Symptom Review – Answer Yes or No

1. Discomfort, aching, or fatigue in leg(s) when walking? _____
2. Skin color changes or blackened toes? _____
3. Numbness in feet? _____



OFFICE USE ONLY – DO NOT COMPLETE THIS SECTION LVN INITIAL _____

☐ ORDER VENOUS REFLUX STUDY (VEIN) ☐ ORDER ABI STUDY (ARTERIAL)

IF THERE ARE ANY QUESTIONS REGARDING THE TEST PLEASE DISCUSS WITH YOUR PHYSICIAN

PHYSICIAN COMMENTS: _____

PACIFIC CARDIOVASCULAR ASSOCIATES MEDICAL GROUP, INC.
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NOTICE OF PRIVACY PRACTICES

Privacy Officer: Alison Ruggio, MPA, Manager of Administration and Outreach Services, **Telephone (877) 430-7337**

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 our 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 Pacific Cardiovascular Associates Medical Group, Inc. (PCA) May Use or Disclose Your Health Information

PCA 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 PCA, 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 in order to receive our payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate our medical practices. 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 federally mandated fraud and abuse detection and compliance programs as well as business planning and management. We may also share your medical information with our "business associates." We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. ***We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.***

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will

give you the opportunity to object prior to making these disclosures, although we may disclose this information in an emergency or 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 other concerned responsible parties.

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 our practice and tell you which health plans we participate in.

We may remind 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 or for the prevention of illness, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration if any; and (2) your right to opt-out of future remunerated communications by calling our phone number: **(877) 430-7337**. We will not otherwise use or disclose your medical information for marketing purposes without your prior written authorization.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, incompetence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. We are required by law to notify the DMV if we feel you present a driving risk to yourself or others. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons or agencies in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. 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.

17. 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.

18. 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.

19. Change of Ownership. In the event that our medical practice is restructured, 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.

20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our "business associate" may provide the notification. We may also provide notification by other methods as appropriate.

21. 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.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When PCA May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, PCA will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize PCA 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 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 PCA amends 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 PCA'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 PCA, except that PCA 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 17 (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 PCA has received notice from that agency or official that providing this accounting to you would be reasonably likely to impede their activities.

6. Right to Notice. 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. 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 we handle 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.