Wenche Chung, MD & Kuoting Lee, LAc

Patient Registration

_____New Patient _____ Established Patient/ Updates

Patient Information

Last name:_____ First:_____ Middle:_____

DOB: _____ Sex: M ☐ F ☐ Marital Status: S M W D ☐ ☐ ☐ ☐

DL#_____

Home Address:_____

Phone: Cell_____ Home _____Work_____

Primary Language: English (please specify_____)

Hearing Impairment: No SS#_____

Sign me up with the Portal:

E-mail Address:_____

Ethnicity: (Optional) (Please specify_____)

Emergency contact

Last Name:_____ First:_____ Relationship:_____

Address:_____

Phone: Cell_____ Home_____

Employer information:

Employer:_____ Occupation: _____Date Employed: _____

Address:_____

Responsible Party Information: (Do not complete if the patient is the responsible party).

Last name: _____ First: _____ Middle: _____

DOB: _____ Sex: Marital Status: S M W D
DL#_____

Home Address:_____

Phone Numbers: Cell_____Home _____Work _____

Patient Name:

Health plan Information

Primary insurance

Health plan: _____ **Eff. date:** _____

ID#: _____ **Plan:** _____ **Group** No.: _____

Subscriber: **Phone#**_____

Insurance Address: _____

Secondary Insurance: **Medical Identification #:** _____

Spouse/Other Parent health plan: **Eff. Date:** _____

ID#: _____ **Plan:** _____ **Group #:** _____

Subscriber: _____ **Phone:** _____

Insurance Address:

Form Completed By: _____ **Signature:**

Relationship to patient _____ **Date:** _____

Patient Complaint

Past medical History: Hypertension☐ Diabetes☐ High Cholesterol☐ Seizure☐ Stroke☐ Heart☐ Failure Heart Attack☐ Depression☐ Dementia☐ Asthma☐ Emphysema☐ Kidney Disease☐ Thyroid ☐ Prostate☐ Breast Disease☐ Ovary Disease☐ Cancer ( ).

Past surgeries:

Family History: Hypertension☐ Diabetes☐ High Cholesterol☐ Seizure☐ Stroke☐ Heart☐ ailure Heart Attack☐ Depression☐ Dementia☐ Asthma☐ Emphysema☐ Kidney Disease☐ Thyroid ☐ Prostate☐ Breast Disease☐ Ovary Disease☐ Cancer ( ).

Allergy to Medication:

Immunizations: Tetanus☐ Shingle☐ Flu☐ Pneumovax☐ Prevnar13☐ Other

Smoking **Alcohol** **Drug**

Current Pharmacy:

Mail Pharmacy:

Medications:

Wenche Chung, MD. & Kuoting Lee, LAc

909 S. Santa Anita Ave., Ste #B, Arcadia, CA 91006

Authorization for Treatment & Financial Agreement

I consent to treatment as necessary or desirable to the patient named below, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, nurse or qualified designate.

I authorize the release of any medical or other information necessary to process any medical claims. I also authorize payment of medical benefits directly to the attending physician or supplier for services rendered.

____I understand that the Doctor's office will bill my primary insurance company as a courtesy, and that I am to present a current insurance card to be copied at each visit. If my insurance requires a claim form for services rendered, I will provide the billing department with a complete and signed claim form. I understand that this office only files claims with my primary insurance company and that I must submit charges to my secondary insurance on my own.

____I understand that I will be responsible for all charges if I cannot produce an insurance card and/or eligibility at the time of service since the billing department has only 30 days in which to file a claim, and needs these items to complete my claim in a timely manner.

I understand that I must complete the patient information form and will provide all information requested for the billing department to submit a claim to my insurance company. I understand that an incomplete form may delay my claim, therefore leaving me responsible for all charges incurred due to lack of information.

In the event that my insurance company does not pay for a service within 60 days of the service date, denies payment for any reason, determines that a service is not covered (e.g., pre-existing condition, non-medical necessity), or pays less than anticipated, I agree to pay the unpaid amount within 30 days (including amounts applied to my deductible).

CO-PAYS ARE DUE AT THE TIME OF SERVICE (Cash or Check only Please)
A photocopy of this authorization will be-considered as valid and legally binding as the original.

PRINT Patient's Name: _____

SIGNATURE of Parent or Legal Guardian: _____ **Date:** _____

I Understand That Wenche Chung, MD is licensed and regulated by the medical board of California. Phone # 800-633-2322

www.mbc.ca.gov

Patient Name: _____ **Signature:** _____

Wenche Chung, MD. & Kuoting Lee, LAc

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Wenche Chung, MD.& Kuoting LAc., to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Wenche Chung, MD.& Kuoting LAc., APC' s Notice of Privacy Practices provides a more complete description of such uses and disclosure.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wenche Chung, MD.& Kuoting LAc., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Wenche Chung, MD.& Kuoting LAc., Privacy official at 909 S. Santa Anita Ave., STE# B, Arcadia, CA, 91006.

With this consent, Wenche Chung, MD.& Kuoting LAc., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointments reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Wenche Chung, MD.& Kuoting LAc., may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Wenche Chung, MD.& Kuoting LAc., may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder and patient statements. I have the right to request that Wenche Chung, MD.& Kuoting LAc., restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting toWenche Chung, MD.& Kuoting LAc., use and disclosure of my PH1 to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Wenche Chung, MD.& Kuoting LAc., may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Patient's Name _____

Print Name of Patient or Legal Guardian_____ **Date:** _____

Wenche Chung, MD. & Kuoting Lee, LAc

PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION WITH OTHER INDIVIDUALS

Instructions:

1. Write the name of all family members or other individuals who are involved in the patient's health care, and have the patient or the patient's Personal Representative sign and date the form.
2. If the patient's Personal Representative is signing the form on behalf of the patient, the Personal Representative must also sign and date the acknowledgement that he or she has the legal authority to do so.

Individuals to whom Wenche Chung, MD, may disclose my Personal Health Information for coordination of care purposes I hereby grant Wenche Chung, MD, its subsidiaries, and associated organizations permission to discuss my health information with the persons listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

	Name	DOB	Relationship (friends, relatives, etc.)	Phone#
1.				
2.				
3				
4				
5				

I understand that if I do not list anyone and I am not present or am incapacitated, Wenche Chung, MD, may share my information with family, friends or others that Wenche Chung, MD, has determined, based on professional judgment, that is in my best interest and necessary for coordination of care and/or payment for health care services I have received from Wenche Chung, MD.

This form supersedes any and all previously completed forms. All previous forms are hereby revoked.

Signature of Patient or Legal Representative_____ **Date:**_____

I understand that I have the ability to revoke identified representatives at any time by making modifications directly to the form and/or choosing to revoke all rights with all identified individuals be selecting option below.

__ Revoke all rights to discuss Personal Health Information with all individuals mentioned above

Signature of Patient or Legal Representative_____ **Date:**_____

Personal Representative Acknowledgement

If the patient is a minor or has a personal representative, I represent that I am the legal Personal Representative of the patient named above and I have the legal authority to act on behalf of the patient in making decisions related to health care.

Signature of Patient or Legal Representative_____ **Date:**_____

Print Name of Patient or Legal Representative_____ **Date:**_____

Wenche Chung, MD. & Kuoting Lee, LAc

Advance Healthcare Directive Acknowledgement

My initial next to one of the following statements indicates my current Advance Directive status:

___ I have provided a copy of my Advance Healthcare Directive form to **Wenche Chung**, MD, Inc. to be placed in my chart.

___ I will provide a copy of my Advance Healthcare Directive to **Wenche Chung**, MD, Inc.

___I do not have an Advance Healthcare Directive at this time, I understand that it is my responsibility to discuss this matter with my primary care provider.

My Signature acknowledge that I have informed **Wenche Chung**, MD, Inc. of my right to participate in making decisions about my medical treatment by executing an Advance Healthcare Directive.

Patient Signature _____ **Printed Name** _____ **Date:**

Witness Signature_____ **Printed Name** **Date:**

Written and verbal information was provided to the patient (Advance Healthcare Directive Packet).

For free advance medical directive, you can Google:

advance directive California AARP

HIPAA Summary of Notice of Privacy Practices and Acknowledgment Form

By signing below, I acknowledge that Wenche Chung, MD, Inc has provided me with a complete copy of his Notice of Privacy Practices. This is a summary of the information in the complete Notice of Privacy Practices

My Rights. I have the right to:

Get a copy of my paper or electronic medical record, Request corrections to my paper or electronic medical record, Request confidential communication, Ask us to limit the information we share, Get a list of those with whom we've share your information, Get a copy of the complete Notice of Privacy Practices, File a complaint if I believe my privacy rights have been violated.

My Choices. I have some choice in the way the facility uses and shares my information as it:

Tells family and friends about my condition, assists in disaster relief efforts, markets its services, and sells my information

We may use and share your information as we:

Treat you, Run our organization, Bill for services, Help with public health and safety issues, Do research, Comply with applicable laws, Respond to organ and tissue donation requests, Work with a medical examiner or funeral director, Address workers' compensation, law enforcement, and other governmental requests, Respond to lawsuits and legal actions.

I have had the opportunity to review the complete Notice of Privacy Practices prior to signing this acknowledgment.

I am aware that the facility reserves the right to change the terms of their Notice of Privacy Practices and to make new provisions effective for all protected health information that they maintain. In the event of amendment(s), the facility will make available a revised Notice of privacy Practices on its website and at its treatment locations.

Print Name of Patient or Personal Representative: _____ **DOB:** _____

Signature of Patient or Personal Representative: _____ **Date:** _____

If personal Representative signs, please state relationship to patient and explain authority to sign

This section is to be completed by Wenche Chung, MD. & Kuoting Lee, LAc APC if unable to obtain written acknowledgment from patient.

I made a good faith effort to explain the purpose and content of Privacy Practices to the patient or his/her representative and to obtain an acknowledgment from the patient or his/her representative that the Notice of Privacy Practices was received, but (check one):

Patient or representative refused to sign.

Patient was in an emergency treatment situation during first service delivery, and the notice of Privacy Practices was provided as soon as was practicable after the emergency treatment situation passed.

Other (list reason why acknowledgment was not obtained):

Facility Name and Address: _____

Employee Signature: _____ **Date:** _____

Printed Name and Title of Employee: _____

NOTICE OF PRIVACY.PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provided penalties for covered entities that misuse personal health information.

We may use and disclose your medical records only for each of the following purposes:

1, TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

2. PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

3. HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. 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.

Any other uses and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except for the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosure of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of our protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of /\pril 14, 2003 and we are required to abide l,y the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint: The U.S Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, (202) 619-0257

Revised 02/18/20

NOTICE OF PRIVACY PRACTICES

Wenche Chung, MD. & Kuoting Lee, LAc

909 S Santa Anita Ave., Suite B, Arcadia CA 91006

Effective Date: _____

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

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

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

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality

assessment and improvement activities, their patient-safety activities, their population based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. *[Participants in organized healthcare arrangements only should add:* We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. Optional: 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 tissue

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

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

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 any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the

information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

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

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D Changes to this Notice of Privacy Practices

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

E. Complaints

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

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

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

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