



The following are required patient notices:

OPEN PAYMENTS DATABASE NOTICE

Pursuant to Assembly Bill (AB) 1278, physicians are required to provide a notice to their patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS.

- The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.
- For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

CALIFORNIA MEDICAL BOARD NOTICE

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint to to

www.mbc.ca.gov

email: licensecheck@mbc.ca.gov

or call (800) 633-2322

I have been informed of and reviewed the notices above.

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your healthcare provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the healthcare provider's practice, or other uses required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician or their medical office that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. Since we do not bill your insurance company directly, this is unlikely. But in rare cases, health insurance companies may request information from our office if you have submitted a claim to them for reimbursement.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to physical therapy students that work with patients in our office. We may also use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Abuse or Neglect cases; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Criminal Activity; Military Activity and National Security; Workers' Compensation; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your healthcare provider believes it is in your best interest to permit use and disclosure of your protected health

information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
 - The patient may revoke this consent in writing at any time, and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this consent. The patient acknowledges that he/she has been given the opportunity to obtain a copy of our HIPAA practices.

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from today's date to exactly one year from today.

By signing this form, you authorize our use and disclosure to third parties, including but not limited to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you in this facility. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on our prior authorization.

The patient understands and agrees that:

- The Clinic has a Notice of Privacy Practices. The patient has received and had the opportunity to review, this Notice before signing the Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.
- The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with change in the law or office practices. We will make all modifications available for review by patients.
- All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations. The Clinic will not receive any payment from a third party in connection with the use or disclosure of your PHI.
- The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We WILL NOT ever sell or 'SPAM' your personal contact information.
- The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.
- The patients may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.
- The Clinic may not condition your treatment or payment on whether you sign this Authorization.
- Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipients and may no longer be protected by federal or state law.