ORTHOPEDIC SPECIALTY CENTER
HI-DESERT

Welcome to Seip Orthopedic Surgery. We thank you for choosing us for your orthopedic medical needs.

Please take a moment and complete the attached patient information packet. Remember that the more thorough you are the more efficient we will be.

IF YOU HAVE BEEN INVOLVED IN AN AUTO ACCIDENT, INJURED AT WORK, OR ANY OTHER PERSONAL INJURY…

WE WILL NOT ACCEPT YOUR PRIVATE INSURANCE!!!

PERSONAL INJURY: Means that your injury is due to a person, store, or accident by another party who caused the injury and you are saying they are at fault and taking action.

We do not accept personal injuries on a lien basis. You will be required to pay as you go. You may seek reimbursement through the 3rd party or attorney handling your case.

If you misrepresent yourself by giving us your private insurance, we will refund your insurance company and you will have 5 (five) days to pay us in full prior to collection proceedings.

PLEASE ONLY SIGN 1 (ONE) OPTION:

*I have read all the above and hereby confirm I **HAVE** been involved in an auto accident, work injury, or any other type of PERSONAL INJURY for the reason I am seeking care today.*

_____ _____

Patient Signature ***Date***

*I have read all the above and hereby confirm I **HAVE NOT** been involved in an auto accident, work injury, or any other type of PERSONAL INJURY for the reason I am seeking care today.*

_____ _____

Patient Signature ***Date***

SEIP ORTHOPEDIC SURGERY
PATIENT MEDICAL HISTORY

Patient Name:_____ **DOB:**_____ **M / F**

Today's Date:_____ **Date of Injury:**_____ **Are you? RT or LT handed**

Primary Care Physician:_____ **Pharmacy:**_____

Were you sent to our office by a physician? ☐ **Yes** ☐ **No If yes, who?**_____

HISTORY OF PRESENT ILLNESS: **HT:**_____ **WT:**_____ **lbs.** **AGE:**_____ **yrs.**

Why are you here today?_____

Location: **RT / LT**_____ **Quality:**_____
Where is the pain / problem? Does it travel to other areas? Is the pain dull, throbbing, sharp? Warm, tender, red?

Severity:

Duration: _____
How long have you had this pain / problem?

Associated signs / symptoms:_____
Example: numbness, tingling, weakness, instability, popping, grinding, swelling, stiffness, etc.

Modifying Factors:_____
What makes the pain / problem worse or better?

Your Expectations:_____
What result do you expect from your care? Relief from pain, Return to job or leisure activities, Improved sleep?

Have you seen any other physicians regarding THIS body part? ☐ **Yes** ☐ **No**

Doctor Name	When	Tests	Results	Treatment

PAST HISTORY OF PRESENT ILLNESS:

Have you ever experienced any injury or symptoms regarding THIS body part? ☐ **Yes** ☐ **No**
If yes, please provide details:_____

_____

Occupation:_____ **Hobbies / Sports:**_____

Which of the above activities are you unable to perform due to your pain?_____

PAST MEDICAL HISTORY: *Have you ever had any of the following? Please check all pertinent boxes:*

☐ Aids or HIV +	☐ Bronchitis	☐ Hepatitis	☐ Mumps	☐ Thyroid Disease
☐ Anemia	☐ Chicken Pox	☐ High Blood Pressure	☐ Pneumonia	☐ Tuberculosis
☐ Arthritis	☐ Diabetes	☐ Infectious Mono	☐ Polio	☐ Ulcer
☐ Asthma	☐ Diphtheria	☐ Kidney Disease	☐ Rheumatic Fever	☐ Venereal Disease
☐ Back Trouble	☐ Epilepsy / Seizures	☐ Low Blood Pressure	☐ Scarlet Fever	☐ Whooping Cough
☐ Bladder Infections	☐ Glaucoma	☐ Measles	☐ Sleep Apnea	☐ Other (please list)
☐ Bleeding Tendency	☐ Heart Disease	☐ Migraine Headaches	☐ Smallpox	☐ _____
☐ Blood Transfusions	☐ Hemorrhoids	☐ Mitral Valve Prolapse	☐ Stroke	☐ _____

PLEASE COMPLETE OTHER SIDE...

MEDICATIONS: *Include non-prescription & Herbal Supplements*

☐ **NO MEDICATIONS** ☐ **LIST ATTACHED**

Drug Name	Dosage	Frequency

ALLERGIES:

☐ **NO KNOWN DRUG ALLERGIES** ☐ **TAPE ALLERGY** ☐ **LATEX ALLERGY**

Medication Name	Reaction

PAST SURGICAL / HOSPITALIZATION HISTORY:

☐ **PROBLEMS WITH ANESTHESIA** _____

Date	Surgery / Illness	Doctor / Hospital	City, State

PATIENT SOCIAL HISTORY:

Marital Status

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Separated

Use of Alcohol

☐ Never
☐ Rarely
☐ Moderate
☐ Daily

Use of Tobacco

☐ Never
☐ Previously, but quit
☐ Currently
_____Packs per day

Living Situation

☐ At Home
☐ With Family
☐ With Friends
☐ Alone
☐ Other

FAMILY MEDICAL HISTORY:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			

REVIEW OF SYSTEMS: *Please indicate any personal history below: (please circle all that apply)*

Musculoskeletal

Joint Pain	No	Yes
Joint Stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold Extremities	No	Yes
Difficulty in walking	No	Yes

Constitutional Symptoms

Bad general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Ears / Nose / Mouth / Throat

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems	No	Yes
Nose bleeds	No	Yes
Bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Cardiovascular

Heart Trouble	No	Yes
Chest Pain or angina pectoris	No	Yes
Palpitations	No	Yes
Shortness of breath, while walking	No	Yes
Swelling of feet, ankles, or hands	No	Yes

Genitourinary

Frequent Urination	No	Yes
Burning or painful urination	No	Yes
Blood in Urine	No	Yes
Incontinence of dribbling	No	Yes
Female – number of pregnancies	_____	
Female – number of deliveries	_____	

Integumentary (skin, breast)

Rash or itching	No	Yes
Changes in skin color	No	Yes
Varicose veins	No	Yes
Breast Pain	No	Yes
Breast Lump	No	Yes

Neurological

Light headed or dizzy	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

Endocrine

Excessive thirst or urination	No	Yes
Heat or cold tolerance	No	Yes
Skin becoming dryer	No	Yes

Hematologic, Lymphatic

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Enlarged glands	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Rectal bleeding	No	Yes
Blood in stool	No	Yes
Abdominal pain	No	Yes

Respiratory

Chronic or frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses / contacts	No	Yes
Blurred or double vision	No	Yes

Allergic / Immunologic

List food / environmental allergies:

_____
_____
_____

_____ _____

Signature of Patient or Parent of Minor ***Date***

SEIP ORTHOPEDIC SURGERY

OSTEOPOROSIS RISK AND NARCOTIC PRESCRIPTION POLICY

If you are past menopause, you may be at risk for osteoporosis.
Check any of the following that may apply to you.

	I am Caucasian (white) or Asian.
	I have a family history of osteoporosis.
	I have a small, thin frame.
	I do not have adequate physical activity.
	I drink alcohol excessively and/or smoke.
	I am not getting enough calcium (at least 1200mg) and/or vitamin D (800-1000 IU) each day.
	I have lost height.

You are at greater risk of osteoporosis or fracture with even just one of these risk factors. Please talk to your Doctor or other healthcare professional about your bone health. If you are at risk of osteoporosis or already have it, your Doctor can advise you how to take steps to protect your bones.

NARCOTIC (PAIN) PRESCRIPTION POLICY

The Doctors in this practice prescribe Narcotic Medications ONLY in cases of acute injury and after surgery for a period of NO MORE than 4 (four) weeks. If you require long term pain control, you will need to discuss this with your Primary Care Physician or be referred to a Pain Management Specialist.

Our office requires 48 (forty-eight) hours to process narcotic prescription refills with no guarantee of approval.

Please contact your pharmacy so you will not run out of medication while waiting for your prescription to be processed.

By signing below I acknowledge the Narcotic Prescription Policy:

Signature of Patient or Parent of Minor

Date

SEIP ORTHOPEDIC SURGERY
Biographical Information Data Sheet

Patient Information					
Name (Last, First, Middle)		Social Security Number	Birth Date	Sex	
Address		City, State, Zip			
Home Phone	Cell Phone	Marital Status	Primary Language	Pharmacy Used	
Emergency Contact Name	Emergency Contact Phone Number	Drivers License Number & State	E-Mail Address		
Patient Employer Information					
Employer Name	Employer Phone Number	Employer Address			
Responsible Party (if different from above)					
Name (Last, First, Middle)	Relationship	Social Security Number	Birth Date	Sex	
Address		City, State, Zip			
Responsible Party Employer Information					
Employer Name	Employer Phone Number	Employer Address			
Insurance Information					
Primary Insurance Name	Subscriber Name	Policy Number	Group Number		
Secondary Insurance Name	Subscriber Name	Policy Number	Group Number		

Notice of Privacy Practices:

_____I have received and reviewed the notice of Seip Orthopedic Surgery's Privacy Practices. I understand this notice describes how information about me may be used and disclosed and how I can get access to this information.

Advanced Directive:

_____I have been informed of my rights to formulate an Advanced Health Care Directive. Should I have any questions regarding this directive I will discuss them with my health care provider.

Authorization and Release:

_____I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of Seip Orthopedic Surgery. I hereby authorize Seip Orthopedic Surgery to release any information acquired in the course of my examination or treatment to assist in the payment of such treatment.

_____(Patient or Responsible Party) am an eligible member as of this date of service of a health plan and a copy of the benefits card is attached to this document. Signature of responsible party below acknowledges full financial responsibility of services rendered to me if it is determined I am not eligible on the date of service in question or if the service rendered is determined to a noncovered benefit under the plan provisions.

_____I hereby irrevocably authorize payment directly to Seip Orthopedic Surgery, benefits otherwise payable to me but not to exceed Seip Orthopedic Surgery's regular charge due as a result of this claim. I understand I am financially responsible to Seip Orthopedic Surgery for any charges not covered.

_____ _____

Patient / Responsible Party Signature **Date**

SEIP ORTHOPEDIC SURGERY
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 right 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 services 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 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 thereafter. 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.

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 the 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 provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 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.

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 statue 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 arbitration 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 and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If the 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's Representative's Initials

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 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**:** _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Jeffrey D. Seip, M.D. (Date)

By: _____
Patient's Representative's Signature (Date)

_____
Print Name and Relationship to Patient

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

SEIP ORTHOPEDIC SURGERY
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize **SEIP ORTHOPEDIC SURGERY** to furnish health information as described below on:

   PATIENTS NAME: _____ **DOB:** _____

2. **This authorization is limited to the following type and amount of information:**
   - o NO INFORMATION
   - o All medical information for the last 2 years
   - o Medication List
   - o Laboratory results from (date)_____to (date)_____
   - o X-ray and imaging reports from (date)_____to (date)_____
   - o All records relating to injury: (date)_____to (date)_____
   - o Immunization Record
   - o Other (specify)_____

3. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse, and /or mental health services.**

4. THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:
   NAME:_____**SELF**_____
   NAME:_____(CIRCLE): spouse / child / caregiver / friend / other

5. The recipient may use the medical records and type of information authorized only for the following purposes: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Services Dept. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____
   If I fail to specify an expiration date, event or condition, this authorization will expire 1 (one) year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or request copies of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Office Manager.

_____ _____

Signature of Patient or Legal Representative / Relationship to Patient Date

SEIP ORTHOPEDIC SURGERY
NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice please contact our Privacy Officer who is KRISTINA TIBBETTS.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, 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. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, wewill have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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 physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting such restriction in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Kristina Tibbetts** at (760)365-2520 or (760)228-1800 for further information about the complaint process.

This notice was published and becomes effective on January 1, 2003**.**