

**ASSOCIATED
FAMILY
PHYSICIANS**

SACRAMENTO OFFICE
8110 TIMBERLAKE WAY
SACRAMENTO, CA 95823
PHONE: (916) 689-4111
FAX (916) 405-1409

GALT OFFICE
417 C STREET
GALT, CA 95632
PHONE: (209) 745-1778
FAX (209) 745-9187

MRN#

REGISTRATION FORM

Name _____ Date of Birth _____ Phone _____
Address _____ City _____ State _____ Zip Code _____
Cell _____ Work Phone _____ Alternate Phone _____ Gender: M / F
Marital Status: S M D W Spouse Name _____
Race/Ethnicity: American Indian Asian Black Native Hawaiian White Hispanic Origin
 Non-Hispanic Origin Other _____
Email _____ Drivers License No. _____
Social Security No. _____ Occupation/ Employer _____
Emergency Contact _____ Relation _____ Phone _____
How did you hear about us? _____

INSURANCE

Primary Policy

Plan Name _____
Policy ID _____
Group ID _____
Subscriber _____

Secondary Policy

Plan Name _____
Policy ID _____
Group ID _____
Subscriber _____

I understand by signing this document I am giving Associated Family Physicians permission to bill my insurance for any services rendered at either of their facilities. I understand any balance not covered by my insurance is my responsibility in full. I authorize direct payment of medical insurance benefits to Associated Family Physicians, Inc. I also authorize the release of any necessary information to process claims under the insurance policy. If you have any questions about your medical benefits or bills please call our office at (916) 689-4111.

Name _____ Signature _____

MEDICATION AND ALLERGIES

Please List all medications Below:

Medication Name/Dose/Frequency

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please List all Allergies and reactions Below: (Rash, Difficulty Breathing, swelling, nausea etc.)

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FAMILY MEDICAL HISTORY

- | | | | | | | |
|----------------------|-----------------|--|---------------------------------|-----------------------------------|---------------------------------|----------------------------------|
| Father: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Mother: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Sibling 1: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Sibling 2: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Sibling 3: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Sibling 4: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Child 1: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Child 2: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Child 3: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |
| Child 4: Age _____ | Deceased: Y / N | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP |

PERSONAL MEDICAL HISTORY

General Well-Being

- Fatigue/Weakness
- Fever
- Loss of Appetite
- Weight Gain
- Weight Loss

Eyes

- Blurred or Double Vision
- Corrective Lenses
- Eye disease or Injury
- Glaucoma

Ears, Nose, Throat, and Mouth

- Difficulty Swallowing
- Hearing Difficulties
- Neck Injury
- Nose Bleeds
- Sinus Problems
- Sleep Apnea
- Snoring
- Other _____

Skin

- Rash
- Ulcer
- Eczema
- Other _____

Cardiovascular (Heart)

- Abnormal Heart Rhythms/Palpitations
- Arm, Neck, or Jaw Pain
- Chest Pain
- Defibrillator/Type _____
- High Blood Pressure
- Leg Pain (Claudication)
- Pacemaker/Type _____
- Angiogram Date _____
- Balloon Angioplasty/Stent Date _____
- Heart Attack/Date _____
- Heart Surgery/Date _____
- Vascular Surgery or Procedure
- Shortness of Breath
- Dizziness/Syncope
- Rheumatic Fever
- Murmur
- Other _____

Musculoskeletal

- Joint Pain(s)
- Arthritis
- Back Injury or Surgery
- Muscle Problem or Injury
- Other _____

Neurologic

- Alzheimer's
- Dementia
- Brain Injury
- Seizures/Convulsions
- Dizziness
- Insomnia
- Memory Loss/Confusion
- Migrains/Headaches
- Numbness
- Stroke
- Weakness
- Other _____

Psychiatric

- Anxiety
- Depression
- Psychosis
- Schizophrenic
- Closterphobic
- Other _____

Endocrine

- Diabetes
- High Cholesterol
- Over Weight
- Thyroid Gland Disease

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PERSONAL MEDICAL HISTORY CONTINUED...

Gastroenterology (Stomach)

- Abdominal Pain
- Heartburn/ Acid Reflux
- Diarrhea
- Constipation
- Nausea
- Vomiting
- Ulcers
- Intestinal Disease _____
- Gallbladder Disease
- Liver Disease _____
- Cirrhosis of Liver
- Hepatitis
- Other _____

Hematology (Blood Disorders)

- Cancer/Type _____
- Cancer Treatment _____

For Women ONLY

- Breast Disease
- Post Menopausal
- Uterine Disease
- Vaginal Bleeding
- Other _____

Respiratory

- Asthma
- COPD
- Emphysema
- Shortness of Breath
- Tuberculosis
- Other _____

Hematology (Blood Disorders)

- Anemia
- Bleeding
- Blood Clots
- Transfusions
- Other _____

Extremities (Arms/Legs)

- Swelling
- Bruising
- Other _____

For Men ONLY

- Breast Disease
- Prostate Disease
- Sexual Dysfunction
- Other _____

Urinary

- Bladder Disease
- Difficult/Painful Urination
- Incontinence/Bladder Leakage
- Kidney Stones
- Kidney Disease
- Other _____

Infections

- Diphtheria
- Hepatitis Type
- Herpes Zoster (Shingles)
- Measles
- Mumps
- Scarlet Fever
- Rheumatic Fever

List all current symptoms and concerns

List all surgeries and approximate dates

List all serious injuries and/or accidents

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SOCIAL HISTORY

Tobacco

- Current Everyday Smoker
- Current Smoker, Not Everyday
- Former Smoker
- Never Smoker

If you are/have used tobacco please write the number of years and usage amount per day

- Cigarettes _____
- Cigars _____
- Pipe _____
- Chewing Tobacco _____
- Vape _____

If you have quit tobacco use how long ago did you quit? _____

Alcohol

- Daily Drinker
- Social Drinker
- Never Drinker

If you are/have drank alcohol please answer the below

Total Number of drinks daily _____ Beer _____ Spirits _____

Total Number of drinks a Week _____ Beer _____ Spirits _____

Total Number of drinks a Month _____ Beer _____ Spirits _____

Caffeine

- Never use caffeine
- Number of caffeine drinks a week _____

Recreational Drug Use

- Never used
- Type and Frequency _____

Exercise Regimen _____

Do you have chest pain or tightness with exercise? Yes No

If Yes: Mild Moderate Severe

Questions for your provider

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OUTSIDE RECORDS REQUEST

Name _____ Date of Birth _____

I hereby authorize Associated Family Physicians to request my medical records from:

Name of Provider/Facility _____

Provider/Facility Address _____

Provider/Facility Phone _____ Provider/Facility Fax _____

Information to be released: _____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: _____

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclose: I understand that the recipient may not lawfully further use or disclose health information outside of the duration specifications unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Signature _____ Date _____

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HIPAA CONSENT

Name _____ Date of Birth _____

I hereby give permission to Associated Family Physicians Inc. to share my personal health information with the following person(s) so that these person(s) may assist me with my healthcare issues:

Name of Person(s) who may receive information: _____

Check here to allow our staff to leave detailed messages on your voicemail

I want Associated Family Physicians to share the following health information: (check all that apply)

All Health Information (Including all items below)

OR

Prescription Drug Information

Billing Information

Lab Results

Scheduling Information

Other _____

Associated Family Physicians may share the information designated above with the person(s) listed starting today, _____ until I revoke this authorization. I understand I may revoke this authorization by doing the following or signing a new form to update.

Mailing a written request to:

Associated Family Physicians
Medical Records Department
8110 Timberlake Way
Sacramento, Ca 95823

Faxing a written request to:

Attn: Medical Records
(916) 405-1409

Emailing a written request to:

Medrec@familymd.com

Signature _____ Date _____

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CONFIDENTIALITY NOTICE

Name _____ Date of Birth _____

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

I agree to uphold the confidentiality and HIPAA standards of Associated Family Physicians. I understand that I am not to use or disclose Personal Health Information (PHI) outside of this office in any manner; verbally, electronically, or physically. I understand that if I cause any breach of PHI it could subject me to prosecution under federal and state law. By signing this document I attest I have been given a copy of the Notice of Privacy Practices.

Patient Signature _____ Date _____

Employee Signature _____ Date _____

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ELECTRONIC PRESCRIBING CONSENT

Name _____ Date of Birth _____

Associated Family Physicians is fully integrated to electronic medical records and ePrescribing

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - Like drug interactions and your prescription history.

The benefit for you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Please choose and sign one of the following options.

I Agree: I agree that Associated Family Physicians may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that the only prescriptions downloaded will be prescriptions that I obtain using an insurance card.

Patient Signature _____ Date _____

I Do NOT Agree: I do NOT permit Associated Family Physicians to download my information from Surescripts.

Patient Signature _____ Date _____

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FINANCIAL STATEMENT

Name _____ Date of Birth _____

In order to do our part to help control the high cost of medical care, we require that you provide us with current proof of insurance coverage at the time of visit. This includes new patients and established patients.

Your insurance coverage is a contract between you and your insurance carrier. Our obligation is to collect co-Pays, deductibles, and co-insurances (if your insurance contract has one) at the time of your visit/service.

Our office will verify eligibility (though not guarantee of payment or benefits which may result in a statement after your insurance has been billed).

HMO Insurances: For our HMO Patients (Hills Physicians or Sutter), we will bill in accordance with our contracted agreement with either of these designated IPA's.

PPO Insurances: For our HMO Patients, we will bill as a courtesy for our patients.

Deductibles: If your insurance contract includes a deductible, you will be charged \$75.00 at each office visit to be applied to your deductible. Any further amount exceeding \$75.00 that is required by your insurance policy, will be billed to you and will be due upon receipt. Once your deductible has been met for the calendar year, we will continue to collect your contracted co-pay for each visit thereafter.

In the event you do not have benefits for a service rendered, (Physicals, immunizations, elective procedures, etc.) payment will be due at time of service.

Medi-Cal / Other HMO Groups: We are not contracted with; nor are we able to provide services to patients with any form of Medi-Cal or affiliated IPA's (Independent Physician Association) of UCD, Med Clinic, or Kaiser; we will not bill 3rd party or auto insurances. Our HMO contracts are with Hills Physicians and Sutter Independent Physicians ONLY.

No-Show Policy: Our office charges a \$50.00 No-Show fee for any missed appointments, or cancellations where 4 hours advanced notice is not given. More than three No-Shows will result in discharge from the practice.

I have read, understand, and agree to the statement(s) above. By signing I agree to abide by the financial policies of Associated Family Physicians.

Patient Signature _____ Date _____

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PAYMENT POLICY

Name _____ Date of Birth _____

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare, Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- Insurances:** We participate in most insurance plans. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up to date insurance card, payment in full is required until we can verify your coverage. Knowing your insurance benefits are your responsibility. Please contact your insurance company with any questions regarding your coverage and benefits.
- Deductibles/
Co-Pays:** All Co-Pays must be paid at time of service. We will collect \$75.00 on all PPO plans at each visit until deductible is satisfied. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. Please help us uphold the law by paying your obligated contracted co-pay and deductibles at your visits.
- Non-Covered
Services:** Please be aware that some-and perhaps all- Of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these non-covered services at the time of visit.
- Proof of
Insurance:** We must obtain a copy of your drivers license and current valid insurance to provide proof of coverage. If you fail to provide us with the correct insurance information , you may be responsible for the balance of the claim/service.
- Claim
Submission:** We will submit and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not part of that contract.
- Coverage
changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will be billed to you directly.
- Account
Payments:** If your account is over 45 days past due, you will receive a final notice letter stating you have 15 days to pay your account in full. We do offer payment plans providing you contact us within 30 days of your statement and meet the terms of 60 days to pay off your balance. Please be aware if your account remains unpaid your debt will be sent to a collections agency. Once sent to collections you and your immediate families will be discharges from our practice. You will then have 30 days to find a new provider in which time you can receive acute care only from our office.
- No Shows:** Our policy is to charge for missed appointments not cancelled within four hours. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your scheduled appointments.

By signing this document you are agreeing to abide by these guidelines and understand the policies outlined in this document.

Patient Signature _____ Date _____

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed as well as how you can get access to this information. Please review it carefully.

This privacy notice is being provided to you as a requirement of federal law, the health insurance portability and accountability act (HIPAA).

Our obligations to you:

Maintaining the privacy of protected health information. To give you this notice of our legal duties and privacy practices regarding health information about you.

How we may use and disclose health information:

Described as follows are the ways we may use and disclose health information that identifies your "Health Information." Your health information means any written and oral health information about you, including demographic data that can be used to identify you. This health information that is created or received by your health care provider, and that relates to your past, present, or future physical or mental health or condition. Disclosures of your protected health information for the purposes described in this Privacy notice may be in writing, orally, by facsimile, or by electronic transmission such as email. Except for the following purposes, we will use and disclose health information only with your *written permission*. You may revoke such permissions at any time by writing to our practice's privacy officer.

Treatment:

We may use and disclose health information for your treatment and to provide you with medical treatment and healthcare services. We may disclose health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. For example, we may disclose your health information to a pharmacy to fill a prescription or to a laboratory to order and collect a blood test.

Payment:

We may use and disclose health information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. Examples may include certain communications to your health insurance company to determine eligibility, precertification, benefits, or any other anticipated services that we have scheduled. If you paid out of pocket for a service you have the right to restrict the release of information on that specific service that was paid for.

Health care operations:

We may use and disclose health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care. They are also necessary to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their healthcare operation activities.

Appointment reminders, treatment alternatives, and health-related benefits and services:

We may use and disclose health information to contact you. We may leave computerized messages to remind you that you have an appointment. We also may use and disclose health information to tell you about treatment alternatives or health related benefits and services that may be of interest to you. Information in regards to your appointment time and/or your presence in our office may be released to persons who may call to inquire about you. We may also mail postcards or send emails(on a secure channel) responding to your medical inquiries.

Appointment reminders, treatment alternatives, and health-related benefits and services:

When appropriate, we may share health information with a person who is involved in your medical care or payment for your care, such as your family, a close friend, or translator. We may also notify your family about your location of general condition or in the event of your death. We may also disclose such information to an entity assisting in a disaster relief effort. You may designate a personal representative in writing, who has the same power over information as you do.

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HIPAA NOTICE OF PRIVACY PRACTICES

Special Situations-Uses and disclosures outside of treatment, payment, and health care operations permitted without authorization or opportunity to object.

Required by law:

We will disclose health information when required to do so by international, federal, state, or local law.

To avert a serious threat to health or safety:

We may disclose your health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

Business Associates:

We may disclose health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may disclose your information to our collection agency or for any other means necessary to collect payment for services rendered. Another example may be to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and tissue donation:

If you are an organ donor, we may use or release health information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation and transportation.

Military and veterans:

If you are a member of the armed forces, we may release health information as required by military command authorities. We also may release health information to the appropriate foreign military authority if you are a member of foreign military.

Workers' compensation:

We may release health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public health risks:

We may disclose health information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people or recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by authority.

Health and oversight activities:

We may use or disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes:

If you are involved in a lawsuit or a dispute, we may disclose health information in response to a court or administrative order. We also may disclose health information in a response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.

HIPAA NOTICE OF PRIVACY PRACTICES

Law enforcement:

We may release health information if asked by law enforcement officials if the information is:

- In response to a court order, subpoena, warrant, summons, or similar process
- Limited information to identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of a criminal conduct
- About criminal conduct of our premises
- In an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of person who committed the crime.

Coroners, medical examiners, and funeral directors:

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as necessary for their duties,

National security and intelligence activities:

We may disclose health information to authorized federal officials for intelligence, and other national security activities authorized by law.

Inmates or individuals in custody:

If you are an inmate of a correctional facility or under the custody of law enforcement officials, we may use or disclose health information to the correctional institution or law enforcement official. This release would be made necessary:

- For the institution to provide you with health care
- To protect your health and safety or the health and safety of others
- For the safety and security of the correctional institution

Your Rights

You have the following rights regarding health information we have about you. We may deny your request to the following rights if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. To inspect and copy this information, you must make your request in writing to our privacy officer.

Right to inspect and copy:

You have a right to inspect a copy of health information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. Copies may be made for as long as we maintain your health information. There will be a fee associated with copying and mailing any records.

Right to amend:

If you feel that health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we maintain your health information. Your request must be made in writing. The request must contain a reason to support the amendment, If we approve the request to an addendum it will be attached to your medical record. We may deny a request to addendum if:

- The information was not created by us
- It is not part of the information maintained by or for Associated Family Physicians
- If we determine that the record is complete and accurate

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FAX (209) 745-9187

MRN#

HIPAA NOTICE OF PRIVACY PRACTICES

Right to an accounting of disclosures:

You have the right to request a list of certain disclosures we made of health information for purposes other than treatment, payment, and health care operations, or for which you provided written authorization.

Right to request restrictions:

You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose to someone involved in your care of payment for your care, like a family member or friend. For example, you could ask that we not share information about a specific diagnosis or treatment with your spouse. You have the right to request we not disclose information to your insurance company on a specific service that you have chose to pay out of pocket for. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply to. Under certain circumstances, we may terminate our agreement to restriction. We will attempt to accommodate all reasonable requests.

Right to request confidential communication:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask we only contact you at work or by mail. We will accomodate reasonable requests.

Right to a paper copy of this notice:

You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. Even if we have agreed to receive this notice electronically, you are still entitled to a copy of this notice.

Changes to this notice

We reserve the right to make changes to this notice and make the new notice apply to the health information we already have as well as any information we receive in the future. We will post a copy of our current notice in our facility.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the secretary of the department of health and human services. To file a complaint with our office, contact our privacy officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

Contact person

Our practice's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the privacy officer. Information regarding matters covered by this notice can be requested by contacting the privacy officer.

If you feel that your privacy rights have been violated by this facility you may submit a complaint to our privacy officer by sending a written complaint to:

Associated Family Physicians Inc.
8110 Timberlake Way
Sacramento, Ca 95823
Attn: Privacy Officer

If you believe Associated Family Physicians has not addressed your complaint to your satisfaction you can find instructions for contacting the US Department of Health & Human Services, Office of civil rights at:

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>