ALAMAR HEALTHCARE, INC.

58 WEST LOOP DRIVE CAMARILLO, CA 93010 (805) 484-0055 FAX (805) 484-4439

PROVIDER: ☐ JEFFREY ALLAN, MD ☐ AVAN PATEL, MD NEW CHART # __ __ __ __ __ __ __ __ __

ALL FIELDS IN THE BLACK BOX BELOW MUST BE COMPLETED LEGIBLY

PATIENT HEALTH HISTORY QUESTIONNAIRE

Please advise us of all your medical concerns and conditions. If you are uncomfortable with any question, do not answer it on the form, but bring it up with your provider as all medical information is important to the management of your healthcare. Best estimates are O.K. if you cannot recall specific details. If you have questions, please ask us. We are happy to help. Thank you!

Today's Date ____ / ____ / 20 __ Who referred you to us? Name________________________ City ______________ State ___

Patient First Name ________________ Last Name __________________ Pt. Soc Sec # _______ ____ _______ Pt. Birth Date ____ / _____ / 19 ___

Home Address ______________________ Apt. ___ City ____________ State (CA)______ Zip __ __ __ __ __ Home Tel. # (_____) ______________

Guarantor (person responsible for bill) First ______________Last ____________ Guar Birth Date __/__ / 19__ __ Guar Soc Sec # ________ ____ ________

Guarantor relationship to patient: __ spouse __ domestic partner __ parent __ other ______________________________

Emergency Contact Person _________________ Emerg. Address _________________ City ________Emerg.Phone # (____) ___________ Ext. ____

Employer / Company ______________________________ Address ____________________________________ Suite _________

City ____________________________________ State _______ Zip _______________ Work Tel. # (______) ______________ Ext. _____

Gender: ___ M ___ F Marital Status __Single __ Marr ___Divorced ___ Separated

Is your current health __ Good __ Fair __ Poor? Comments: ____

Name(s) of other physicians / providers caring for you? ______________________________ and ______________________________

Are you (could you be) pregnant? __ Y __ N **PRESENT HEALTH CONCERNS:** ____

____

To Assure Equal Access to Providers, the Federal Government Requests Us to Ask Patients the Following (Answers Optional):

Which best describes your race? □ White/Caucasian □ American Indian or Alaska Native □ Hispanic/Latino □Asian

□ Black/African American □ Native Hawaiian/ Other Pacific Islander □ Some Other Race ________ □ Decline to Answer □ Unknown

How would you rate your ability to speak and understand English? □Very Well □ Well □Not Well □ Not at All □Declined □Unavailable

What language do you feel most comfortable speaking with your doctor or nurse? ___________________________

Do you utilize American Sign Language to communicate due to hearing loss or deafness? □Yes □ No

ALLERGIES OR REACTIONS TO MEDICINES / FOODS / OTHER AGENTS:

Medication / Foods / Other Agents	Reaction or Side Effect

ACTIVE MEDICATIONS: Current prescription & non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

MEDICATION	DOSE	# TIMES PER DAY		MEDICATION	DOSE	# TIMES PER DAY

DISCONTINUED MEDICATIONS: No longer taking prescription & non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

MEDICATION	DOSE	TIMES/DAY
______________________	__________	__________
______________________	__________	__________

FOR OFFICE USE ONLY FOR OFFICE USE ONLY FOR OFFICE USE ONLY

I have verbally reviewed the medical information above with the patient named herein. Initials ______ Date ________, 20___

Provider's Comments: ____

MEDICAL HISTORY UPDATE

Date ______________________ Comments __________________________________ Signature __________________

Date ______________________ Comments __________________________________ Signature __________________

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PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

PAST MEDICAL HISTORY:

Alamar Healthcare, Inc.

CHECK EACH ITEM	YES	NO	DON'T KNOW
CANCER			
Cancer Type___________			
Date of Occur._________			
Cancer Type___________			
Date of Occur._________			
Cancer Type___________			
Date of Occur._________			
CARDIOVASCULAR			
Angina			
Cardiomyopathy			
Congestive Heart Failure			
Edema			
Heart Attack			
Hypertension			
Murmur			
Pacemaker			
Chest Pain			
Palpitations			
Irregular Heart Beat			
Shortness of breath/activity			
Shortness of breath/waking			
CHILDHOOD ILLNESSES			
Chicken Pox			
Pneumonia			
Polio			
Rheumatic Fever			
Scarlet Fever			
DERMATOLOGIC			
Frequent skin infection			
Eczema			
Herpes			
Keratosis			
Toenail fungus			
Shingles			
Skin Cancer			
Skin Ulcers			
Dry Skin			
Rash			
Suspicious Moles			
ENDOCRINE			
Diabetes			
Thyroid _____________			
Hormone Replace't Therap			
Weight change >< 10 lbs.			

WOMEN'S GYNECOLOGIC HISTORY

 # Pregnancies _____ # deliveries ______

 # abortions _____ # miscarriages _____

1st day most recent period __Age at 1st period___

Frequency of periods/month ____ # of days ___

Do you have any concerns about your periods?

__No __ Yes ____________________

Abnormal bleeding or pain __No __ Yes

Vaginal Discharge __No __ Yes

Do you have any concerns about menopause?

__No __ Yes Menopause Year? ________

Date of last mammogram ___ / ___/ ____

Do you perform monthly breast self-exam N / Y ?

___Lumps ____ Tumor ___ Discharge

CHECK EACH ITEM	YES	NO	DON'T KNOW
GASTROINTESTINAL			
Abdominal injury			
Tumors			
Constipation			
Change in bowel habits			
Bowel Incontinence			
Diverticulitis			
Diverticulosis			
Esophageal problems			
Gall bladder problems			
GERD			
G.I. Bleed			
Hernia			
Irritable Bowel Syndr.			
Liver condition			
Pancreatic condition			
Ulcer			
GENITOURINARY			
Nighttime Urination			
Pain with urination			
Blood in urine			
Bladder Infections			
Kidney Stones			
Incontinency			
Prostate Problems			
HEENT			
Blindness			
Cataracts			
Glaucoma			
Double Vision			
Blurred Vision			
Eye Infections			
Ear Infections			
Ear Wax or Discharge			
Hearing Loss			
Ringing in the ears			
Dentures			
Dental Infections			
TMJ – Jaw problems			
Sinus condition			
Mouth sores			
HEMATOLOG- LYMPH			
Anemia			
Blood clotting abnormal			
Blood transfusion			
Spleenectomy			
IMMUNOLOGICAL			
Anaphylactic reaction			
Mononucleosis			
History of transplant			
BREASTS			
Lumps			
Tumor			
Discharge			

CHECK EACH ITEM	YES	NO	DON'T KNOW
MUSCULOSKELETAL			
Arthritis condition			
Back pain			
Fingers change color in the cold			
Fibromyalgia			
Restless Leg Syndrome			
Accident or injury			
Gout			
Joint Pain			
Osteoporosis			
Bursitis			
Leg Cramps w/exercise			
Muscle Cramps			
NEUROLOGIC			
Alzheimer's Disease			
Brain tumor			
Concussion			
Dizziness			
Headaches			
Loss of consciousness			
Memory impairment			
Migraines			
Neuropathy			
Seizure disorders			
Stroke			
Syncope			
Tremors			
Sciatica			
Trigeminal Neuralgia			
Paralysis			
PSYCHIATRIC			
Alcoholism			
Anxiety			
Depression			
Drug/Substance Abuse			
Eating Disorders			
Obsess/Compuls Disord			
RESPIRATORY			
Asthma			
Bronchitis			
COPD - emphysema			
Coughing			
Coughing with blood			
Sleep apnea			
Respiratory allergies			
Pneumonias			
Pulmonary edemas			
Pulmonary embolism			
VACCINATIONS			
HEP A			
HEP B			
TETANTUS (TD) Year?			
Influenza FLU Year?			
Measles			
Mumps			
Rubella			
Varicella Chicken Pox			
Pneumvax Pneumonia Year?			
Zoster Shingles Year?			
OTHER			

SURGICAL HISTORY (Please list all prior operations and dates):

Operation	Date		Operation	Date

FAMILY HISTORY

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other Close Relative
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer Melanoma							
Cancer, Skin (except melanoma)							
Cancer, Ovary							
Cancer, Prostate							
Cancer (unknown)							
Dementia (Alzheimers,other)							
Depression							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy (seizures)							

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other Close Relative
Genetic diseases							
Glaucoma							
Hay fever (Allerg. Rhinit.)							
Hearing problems							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure (Hypertension)							
High cholesterol (Hyperlipidemia)							
Kidney diseases							
Lupus Erythematosis							
Mental Delay Develop							
Migraine Headaches							
Osteoarthritis							
Osteoporosis							
Parkinson's							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other:							
Current Age							
Age at Death							

SOCIAL HISTORY

SUBSTANCES

Tobacco Use Cigarettes ☐ Quit Date _______________ ☐ Never

☐ Current Smoker; packs/day ___ # years ___

Other Tobacco __ Pipe __ Cigar ___Snuff __ Chew

Are you interested in quitting? __ No __ Yes

SEXUALITY – Sexual Activity

Sexually Active: ___ Yes ___ No __ Not currently

Current sex partner(s) is/are: ___ Male ___ Female

Contraception and Protection

Birth Control method ________________ none needed

If sexually active, do you practice safe sex? ☐N/A ☐No ☐Yes

Have you ever had any sexually transmitted diseases (STDs)? ☐No ☐Yes

If yes, please include: ________________ date ___________

Alcohol Use

Do you drink alcohol? ☐No ☐Yes If so, drinks per week ____

Is your alcohol use a concern for you or others? ☐No ☐Yes

Drug Use: Have you used any recreational drugs?_☐No ☐Yes

Have you ever used needles?__☐No ☐Yes

EXERCISE: Do you exercise regularly? ☐No ☐Yes

If so, # exercise times per week ____

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed, or when you lost all interest or pleasure in things that you usually cared about or enjoyed? ☐No ☐Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? ☐No ☐Yes
3. Have you felt depressed or sad much of the time in the past year? ☐No ☐Yes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence in HIPAA compliance and that it is my responsibility to inform Alamar Healthcare, Inc. immediately upon any changes in my medical status and/or healthcare insurance information. I authorize the medical staff to perform any necessary medical services that I may need during diagnosis and treatment by both Alamar Healthcare and assigned independent covering providers, with my informed consent.

Signature ________________________________ Date: _____/_____/ 20____

58 West Loop Drive Camarillo, Ca 93010 Tel. (805) 484-0055 FAX (805) 484-4439 Jeffrey B. Allan, MD Avan M. Patel, MD

FINANCIAL, CREDIT CARD AUTHORIZATION AND CANCELLATION POLICIES

For Private Payment by Patient, PPOs, Traditional Medicare, and all Medicare Advantage Plans

(Please retain a copy of this agreement for your files)

ALAMAR HEALTHCARE PROVIDERS ACCEPT ONLY CERTAIN MEDICARE AND COMMERCIAL PPO PLANS. By signing below, you acknowledge that you have been advised whether our providers are in-network for your plan or out-of-network, meaning that if your plan is an out-of-network PPO, a Cash or High-Deductible Insured Patient, or is an HMO, you will personally be required to pay part or all of the fees incurred by you in receiving our services.

Thank you for choosing Alamar Healthcare, Inc. as your medical services provider. We accept assignment under Traditional Medicare. Acceptance of Medicare Advantage enrollees into the practice is based upon a full payment Cash-at-time-of-service basis. If you are a Medicare Part B beneficiary, Medicare rules for payment apply. If you are not a Medicare Party B beneficiary, such as a commercial PPO plan beneficiary, payment of deductibles and co-payments are expected at the time your treatment is rendered. Uninsured patients or those with high-deductible Plans are enrolled in the Practice upon a full payment Cash-at-time-of-service basis.

Patients must provide current insurance information, including insurance cards, so that we may make a copy. We also require a signed Assignment of Benefits so that insurance payments will be made directly to our office. If these items are not provided, the patient will be asked to pay your balance in full and seek reimbursement form your insurance plan.

Patients are responsible for reading, understanding and written reporting to Alamar Healthcare, with accuracy, your most current insurance information, including changes in Plan, deductibles, co-payments, exclusions, and difference in enrollee rights between in-network benefits and out-of-network benefits. A failure to provide us updated, accurate information will result in patient responsibility for all balances derived from reliance on patient's inaccurate information. Please verify your coverage and determine who your network providers are with your insurance plan PRIOR to your first visit and PRIOR TO EACH SUBSEQUENT VISIT. If your insurance plan requires a pre-authorization for visits or treatments and you do not provide one, you will be responsible for all of the charges.

Payments are due upon service. Patients whose insurance plan requires a co-payment or annual deductible payment for office visits will be required to pay that amount at the time of the visit. If a patient requires hospitalization or care in a residential care facility, or Skilled Nursing Facility, the fees for physician care are due at the time of service, although a statement may not arrive at the patient's billing address until after discharge. **Failure of patient's insurance plan to pay Alamar Healthcare, Inc.** for medical services in a timely manner will result in direct billing of the patient, limited only by Medicare regulations and applicable law. A late fee of $25.00 will be assessed to patients for each individual patient encounter should the patient's account become delinquent in payment for any encounter. In addition, the patient shall accrue interest charges for outstanding balances at the rate of fifteen (15%) percent per year, pro-rated daily, to the extent permitted by law. A $25.00 fee shall apply for bounced checks. **Cash patients must make payment in full at the time services are rendered.**

All services are charged directly to the patient and you, or your guarantor, remains personally responsible for payment. As a courtesy, we will bill your primary and supplemental insurance plan as provided to us by you and make every effort to submit claims promptly. If at any point in time you should be determined "ineligible for service(s) rendered" or services rendered are deemed "not a covered benefit" or their equivalents, you will be responsible to pay your bill in full upon issuance of a billing statement. **If any balance remains after your insurance company has paid, or if any of your insurance carriers do not pay us in full within thirty (30) days,** you will receive a statement from our billing office. All patient balances are due and payable within ten (10) days of the date shown on your billing statement and will be subject to additional billing fees as delineated below, unless other arrangements are made in writing with our billing office. Any account balance remaining unpaid after to (10) days of the billing statement is considered delinquent and may be turned over for collection by a third party, which will result in additional collection agency and/or attorney's fees due by you unless prohibited by law. Furthermore, failure to bring current a delinquent account may result in our notice of intention to terminate our professional relationship with you, our patient.

- **Credit Card Overcharges:** Patient refunds for inadvertent overcharges will be remitted to you by check once the overcharge is discovered, typically at the time of final posting of payments to your account from deriving from cash or your insurance carriers(s).
- **Telephone and in-person consultations with patients and/or family members/caregivers.** Telephone consultations of greater than ten (10) minutes duration with patient/family members/caregivers that occur independently of a patient face-to-face encounter with the provider may result in an additional charge **as permitted under new Medicare rules and rules of other insurers.** Alamar Healthcare, inc. providers will advise patients/family members/caregivers after ten (10) minutes that such charges will accrue, and the provider will indicate whether the charge will accrue to the patient or to the family member/caregiver.

Survival of Obligation. Patient, Authorized Representative (or other responsible party such as guarantor) acknowledges that this financial agreement shall be binding upon the heirs, executors, administrators, trustees, successors, and assignees of patient. Patient or Authorized Representative, in signing this agreement, obligates and binds the patient, successors, and the patient's guarantor to the terms of these policies.

Cancellation of Appointment. Alamar Healthcare, Inc. requires ONE BUSINESS DAY cancellation notice for all FOLLOW-UP appointments and FIRST-TIME VISITS REQUIRE A TWO BUSINESS DAY CANCELLATION NOTICE. You may be billed a $75.00 service fee for failure to give ample notice of cancellation as permitted by Medicare and commercial insurances.

ALAMAR HEALTHCARE PROVIDERS ACCEPT ONLY CERTAIN MEDICARE AND COMMERCIAL PPO PLANS. By signing below, you acknowledge that you have been advised whether our providers are in-network for your Plan or out-of-network, meaning that if your plan does not include our providers as in-network, or is an HMO, you will personally be required to pay the unreimbursed portion of the fees incurred by you in receiving our services at the time of service.

I have read, understand, and agree to the policies herein and acknowledge my responsibility for prompt payment of my account.

____ ____________________

Signature of Patient or Financially Responsible Party Date

Alamar Healthcare, Inc. 58 West Loop Drive Camarillo, Ca 93010 Tel. 805 484-0055 Fax (805) 484-4439

HIPAA Notice of Privacy Practices (NOPP)

Effective Date: *September 20, 2013*

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 the Alamar Healthcare, Inc. Office Manager/ Privacy and Security Compliance Officer at Alamar Healthcare, Inc. 58 West Loop Drive, Camarillo, CA 93010

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, 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 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. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological 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 health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. 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.

Individuals Involved in Your Care or Payment for Your Care. 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 or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As 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 use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

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 use another company 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 transplantation.

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 a 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 of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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 law.

Health Oversight Activities. We may 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

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 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 to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT TO DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Individuals Involved in Your 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. However, disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy 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. To inspect and copy this Health Information, you must make your request, in writing, to the Alamar Healthcare, Inc. Privacy and Security Compliance Officer... We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide

access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

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 the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Alamar Healthcare Privacy and Security Compliance Officer.

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. To request an accounting of disclosures, you must make your request, in writing, to The Alamar Healthcare, Inc. Privacy and Security Compliance Officer.

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 health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Jeffrey Allan, MD, Senior Physician, Alamar Healthcare, Inc. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. 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 that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Jeffrey Allan, MD, Senior Physician, Alamar Healthcare, Inc. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.alamarhealth.com. To obtain a paper copy of this notice, contact the Alamar Healthcare, Inc. Privacy and Security Officer.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS:

Complaints regarding patient rights and provider obligations under HIPAA Security and Privacy federal and California regulations should be addressed to: Alamar Healthcare, Inc. Security/Privacy Officer, 58 West Loop Drive, Camarillo, CA 93010, Tel 805-484-0055.

PATIENT/REPRESENTATIVE SIGNS RELEASE BELOW

PATIENT RECEIPT OF DETAILED NOTICE OF PRIVACY PRACTICES –NOPP

Alamar Healthcare, Inc.

(Print Name of Patient)______________________________________

By signing below, I acknowledge receiving a copy of the “Privacy Notice” of the medical practice designated above, describing my right to privacy of my protected health information (PHI) under the Federal HIPAA Privacy Law, as follows:

- **How my PHI may be used and disclosed,**
- **My privacy rights regarding my PHI,**
- **The Medical Practice’s obligations concerning the use and disclosure of my PHI.**
- **A Special Section on Sensitive Protected Healthcare Information**

Individual’s Signature: ________________________________ Date: __________________

If the authorization is being signed by a personal representative of the individual (such as a parent of a child under the age of 18 or a friend or family member designated by an adult patient):

Personal Representative's Signature: ____________________________Date: _____________

Type/Print Name of Personal Representative:____

File signed original of this form in Patient's Chart

(Patient/Parent/Guardian must be provided with a copy.)

Alamar Healthcare, Inc. 58 West Loop Dr. Camarillo, CA 93010 Tel. 805-484-0055 Fax 805-484-4439

Alamar Healthcare, Inc. Patient Authorization for Disclosure of Health Information

Patient Name ______________________________________ Date of Birth ___/___/19___ Phone: ____________________
Address: ____ City: ___________________ State: _____ Zip: ___________

□ **I request that my protected health information (PHI) from Alamar Healthcare, Inc. be disclosed to:**

Recipient Name: ____
Address: ____________________________________ City: _____________________State:______________ Zip ______________
Phone: ____Fax (healthcare provider only): _____________________

□ **I authorize the following PHI to be released from my medical record(s. This may include, but may not be limited to:**

New patient packet including past medical history, Emergency Room Record, Laboratory Report(s),Radiology Report(s), Pathology Report, Immunization Records, Abstract/ Summary [Includes Discharge Summary, History & Physical, Operative Report(s), Consultations, and Test Results], Radiology film/imaging studies/tracing/media, Itemized Billing Records, and/or
Other:____

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

State and federal law protect the following information related to testing, test results, diagnosis and treatment. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol Abuse, Drug Abuse, and/or Substance Abuse	□ Yes	□ No	Dates: ___________________________________
Sexually Transmitted Diseases (STD)	□ Yes	□ No	Dates: ___________________________________
AIDS/HIV	□ Yes	□ No	Dates: ___________________________________
Mental Health Diagnoses and/or Psychotherapy Notes	□ Yes	□ No	Dates: ___________________________________
Genetic Testing	□ Yes	□ No	Dates: ___________________________________

Covering the period of healthcare from: □ All past, present and future encounters/visits
OR Specific Date(s): from ____to___________________

Purpose for requesting information: □ Legal □ Insurance □ Personal □ Continuation of Care
□ Other ____

Disclosure Format (Paper is default if not marked.): □ US Mail – paper format □ Fax (healthcare provider only)

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to **revoke** this authorization at any time. Revocation must be made in writing and presented or mailed to **Alamar Healthcare, Inc. at the following address: 58 W. Loop Drive, Camarillo, CA 93010.** Revocation will not apply to information that has already been disclosed in response to this authorization.
- ***EXPIRATION OF AUTHORIZATION***: Unless otherwise revoked in writing, this authorization will expire 12 month from the date of this signed authorization.
- Treatment may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

____ _____________________________
Print Name of Patient or Authorized Representative Date

____ _________________________________
Signature of Patient or Authorized Representative Relationship to Patient & Legal Authority

Rev. 04 18 2016
For Office Use Only