PARADISE MEDICAL GROUP, INC.

We would like to take this opportunity to welcome you to Paradise Medical Group for your medical care. Enclosed you will find our new patient paperwork that must be completed 7 days prior to your first appointment. If you have any questions when completing the documents, please call our office at (530) 872-6650.

It is important to your health care that your new provider has your medical history, medication list, and past medical records. When completing the authorization to release medical records please include all physicians that you have seen for health care.

We ask that you complete the following forms and return all forms **7 days prior to your first appointment** either by dropping them off at our office or send them by fax.

On the day of your first appointment, please plan to arrive 20 minutes early so that our staff can get you registered and a nurse can meet with you before visiting with the doctor. Please bring vaccination card and medication list if applicable.

Please bring your most recent insurance cards and an identification card with you to your appointment.

Once again, thank you for choosing Paradise Medical Group for your health care needs. We look forward to meeting you and we are pleased to have you become our patient.

Thank you,

Paradise Medical Group, Staff

Char Bush, NP

6470 Pentz Road Suite B
Paradise, CA 95969

Tel. (530) 877-4911
Fax (530) 877-2171

Robert Grigg, DMSc PA-C MPA
6470 Pentz Road Suite B
Paradise, CA 95969

Tel. (530) 877-9326
Fax (530) 877-2196

Jamaal D. El-Khal, MD

6470 Pentz Road Suite C
Paradise, CA 95969

Tel. (530) 877-7200
Fax (530) 877-7260

Ken Gillen, MS PA-C

6470 Pentz Road Suite C
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Tel. (530) 877-7200
Fax (530) 877-7260

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New Patient – Medical Information

Patient Name: First_____ Middle_____ Last_____

Date of Birth: _____/_____/_____

Who are your current medical providers?	
Provider name	Specialty, or condition for which they treat you

Preventive Care					
	Date		Date		Date
Annual physical		Prostate screen		Cholesterol test	
Colonoscopy		Pap screen		Diabetes screen	
Bone density		Mammogram		Eye exam	
Dental exam					

Immunizations					
	Date		Date		Date
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		Other (please write below)	
COVID (brand/ type)					

Allergies or intolerances to medications?	
Name	Reaction

Please list all medications, supplements, over the counter drugs, creams and inhalers.		
Name	Dose/Strength	Frequency taken

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Please circle all current or past medical problems or conditions.

Heart Failure	ADD/ADHD	Kidney Disease
Coronary Artery Disease	Anxiety	Migraines
MI (Heart Attack)	Depression	Seizures
Valvular Heart Disease	Bipolar Disorder	Glaucoma
Murmur	Substance Abuse	Cataract
High Blood Pressure	Diabetes Type 1	Arthritis
Stroke/ CVA	Diabetes Type 2	Osteoporosis
High Cholesterol	Chronic Obstructive Lung Disease	Valley Fever
GERD/Reflux/Ulcers	Emphysema	Tuberculosis
Anemia	Asthma	Polio
Blood Transfusion	Seasonal Allergies	Sexually Transmitted Infection
Blood Clots	Hyperthyroidism	HIV/AIDS
Cancer Type	Hypothyroidism	Hepatitis Type

Please circle all major operations or surgeries.

	Date:		Date:		Date:
Appendectomy		Coronary Artery Stent		Spine	
Prostate		Cosmetic Surgery		Joint Replacement	
Breast Surgery		Eye		Tonsillectomy	
Uterus/Ovaries		Fracture Repair		Hysterectomy	
Heart Surgery		Hernia Repair		Other	
Gallbladder		Colon/GI		Other	

Family Medical History – Please check the appropriate box if a condition is/was present.

	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	High Cholesterol	High Blood Press	Kidney Disease	Mental Illness	Heart Disease	Stroke/ CVA	Vision Loss	Alzheimer's	Other
Father																				
Mother																				
Brother																				
Sister																				
Children																				
Grandmother (M)																				
Grandfather (M)																				
Grandmother (P)																				
Grandfather (P)																				
Other																				

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Social History

Alcohol Use – Please circle your response.

Glasses of wine per week	0	1	2	3	4	5	6	7	8	9	10+
Cans of beer per week	0	1	2	3	4	5	6	7	8	9	10+
Shots of liquor per week	0	1	2	3	4	5	6	7	8	9	10+
Mixed drinks with 0.5 ounces alcohol per week	0	1	2	3	4	5	6	7	8	9	10+

Sexual Activity – Please check your response.

Sexually active? ☐ Currently ☐ Never ☐ Not Currently

Sexual Partners? ☐ Men ☐ Women ☐ Both

Birth control used? ☐ Pulling out ☐ Condom ☐ Diaphragm ☐ Implant ☐ Inserts ☐ IUD
☐ The Pill ☐ Patch ☐ Rhythm ☐ Spermicide ☐ Sponge ☐ Surgical
☐ Not applicable

Drug Use – Please check your response.

☐ None ☐ Amphetamines ☐ Benzodiazepines ☐ "Crack" Cocaine ☐ Cocaine ☐ Heroin ☐ Marijuana
☐ Methamphetamines ☐ PCP ☐ Huff Gasses ☐ Other

Tobacco Use – Please check your response.

☐ Smoke every day ☐ Smoke some days ☐ Former smoker ☐ Heavy smoker ☐ Light smoker ☐ Never smoked
☐ Second-hand exposure

How many packs/ day average? ☐½ ☐1 ☐1½ ☐2 ☐3 or more
How many years smoked? _____

Have you ever chewed tobacco? ☐Yes ☐No

If you currently use any tobacco product(s), are you ready to quit? ☐Yes ☐No

Hospitalizations

Reason	Year	Comments

Major Injuries

Type	Year	Comments

Advance Directives (Living will and medical power of attorney)

Do you have an advance directive?	☐ Yes	☐ No
Would you like information or a copy of advance directive forms?	☐ Yes	☐ No

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Name: _____ **Today's Date:** _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

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Identification

Patient Last Name _____ First Name _____ Middle name, suffix _____,___

Patient Previous name (last, first) _____

Patient Legal Birth Gender ☐ Female ☐ Male Date of Birth _____/_____/_____ SSN _____-_____-_____

Language _____ Race _____ Ethnicity _____ Marital Status _____

Contact

Patient Mailing Address _____ City, State, Zip Code _____

Patient Physical Address _____ City, State, Zip Code _____

Patient Home Phone (____) _____- _____ Patient Mobile Phone (____) _____- _____

Employment

Employer name _____ Employer Phone (_____) _____ - _____

Usual occupation (current or most recent) _____ Usual industry _____

Legal Guardian

Guardian Last Name _____ First Name _____ Middle name, suffix _____,_____

Guarantor

Relationship to patient ☐Self ☐Other_____

Guarantor Last Name _____ First Name _____ Middle name, suffix _____,_____

Guarantor Date of Birth _____/_____/_____

Guarantor Mailing Address _____ City, State, Zip Code _____
☐Same as patient's address

Guarantor Home Phone (__) _____ - _____ Guarantor Mobile Phone (__) _____ - _____

Paradise Medical Group

AUTHORIZATION REGARDING DISCLOSRES OF HEALTH INFORMATION

Patient Last Name _____ First Name _____ Date of birth ____/_____/_____

I give Paradise Medical Group (PMG) authorization to leave messages to confirm my appointments on my answering machine or voicemail for any and/or all appointments. ☐Yes ☐No

I wish to enable to my Patient Portal Account. ☐Yes ☐No
If yes, my email is _____

Communicator Automated Messaging Preferences→ My mobile number is (_____) _____-_____

Health Notifications	☐Email ☐Phone ☐Text Message
Appointments	☐Email ☐Phone ☐Text Message
Announcements	☐Email ☐Phone ☐Text Message
Billing	☐Email ☐Phone ☐Text Message

I give PMG authorization Health data sharing:

- Patient Record Sharing ☐Yes ☐No
- CAIR (California Immunization Registry) Consent ☐Yes ☐No
- Obtain Medication History Authority ☐Yes ☐No
- Consent to send automated calls to my mobile phone ☐Yes ☐No

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I give PMG authorization to have my family member(s) and/or legal representative(s) listed below to be in the exam room with me at the time of an/all of my visits.
☐Yes ☐No

I give PMG authorization to my family member(s) and/or legal representative(s) listed below to have access to my health information.
☐Yes ☐No

I give PMG authorization to disclose to my family member(s) and/or legal representative(s) listed below regarding my billing issues.
☐Yes ☐No

Family Member/Next of Kin/ Legal Representative	Relationship	Phone Number

Disclosures of Protected Health Information to an individual's friend/family member(s) must be made in accordance with the procedures set forth in PMG's HIPAA Policy/Procedure.

This document does not expire unless date is indicated here: _____

_____ _____
Patient/ Legal Representative Signature Date

Paradise Medical Group

Assignment of Benefits

Patient Last Name _____ First Name _____ Date of birth ___/___/_____

Please complete the requested insurances information and present insurance card(s) and photo ID for copying.

Primary

Insurance Name	Policy ID/Cert#	Policy Holder Name	Policy Holder DOB & Relationship

Secondary

Insurance Name	Policy ID/Cert#	Policy Holder Name	Policy Holder DOB & Relationship

Assignment of Benefits, Release of Billing Information

I, (patient name) _____ hereby assign all medical benefits to Paradise Medical Group, Inc. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to Paradise Medical Group, Inc. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I hereby authorize Paradise Medical Group, Inc. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Paradise Medical Group, Inc. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

_____ _____

Patient/Guarantor Signature Date

Paradise Medical Group

FINANCIAL POLICY

Patient Last Name _____ First Name _____ Date of birth _____/_____/_____

Dear Patient,

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we ask that you read and sign prior to establishing yourself as a patient.

Except as noted below, all charges incurred for services in the office will be due and payable at the time service is rendered.

Exceptions: Medicare, Health Maintenance Organizations, Preferred Provider Organizations and any other ***Paradise Medical Group, Inc. (PMG)*** group contracts. However, all co-pays, deductibles and other appropriate payment responsibility per contract will be expected at the time of service. **Paradise Medical Group does not have a Medi-Cal contract therefore Medi-Cal is not accepted as a primary insurance (accepted only as secondary to Medicare).**

Co-Pays: Co-pays are due and payable at the time of service. As part of your insurance coverage, or government regulations, you have agreed to be responsible for your co-pay and will be expected to pay it at the time of service or your appointment may need to be rescheduled.

Interest: Interest accrues at 1.5% per month (18% per annum) on the outstanding balance of bills unpaid after 90 days from the date of service. If the outstanding balance has not been paid in full the office manager will contact you to arrange a payment plan. If the payment arrangement has not been fulfilled as promised your account will be sent to a collection agency and you will be dismissed from Paradise Medical Group.

Proof of Insurance: You are responsible for providing the physician office with correct and accurate insurance information so that we may bill your insurance company and receive payment in a timely fashion. You must bring your insurance card with you to each visit. At each visit you will be asked to review insurance and personal billing information in our files and will be asked to verify that the information is correct. We will bill your insurance company as a courtesy to you ***however; you are ultimately responsible for payment.***

Second Insurance: We will bill your secondary insurance once.

Payment Methods: We have a variety of payment methods available including cash, check and credit card.

Workers Compensation: At your physician's discretion we provide treatment for work-related injuries. Any charges incurred for this treatment are ultimately the responsibility of the patient. We will need proof of workers compensation coverage from your employer. Once we receive the appropriate information and approval from the employer we will bill them directly for your treatment. However, if they do not pay ***you will be responsible***.

Usual and Customary Rates: We are committed to providing the best treatment for our patients and we set our fees according to what is usual and customary for our area. ***Except where we have agreed contractually with your insurance carrier, you are responsible for payment regardless of your insurance companies' arbitrary determination of usual and customary rates.***

Medicare Non-covered Procedures: You are responsible for any non-covered services requested and will be asked to sign a waiver form indicating responsibility for payment.

Refunds: If your accounts become overpaid, we will promptly refund the overpayment due.

Non-Sufficient Funds Checks: All checks received for payment of services and returned by the bank marked "non-sufficient funds" will be charged to the patient and a non-sufficient check processing charge of $25.00 will be charged.

No Show Appointments: We understand that occasionally patients will be unable to make scheduled appointments due to emergencies. However, unless there is an emergency it is expected that the patient will notify the physician's office within 24 hours of appointment and reschedule the appointment. If you fail to notify the physician of a failure to make a scheduled appointment three times in a row, a charge of $50.00 will be added to your account.

Receipts: We wish to ensure that all patient payments are credited appropriately. Our staff will always provide you a receipt for your payment. However, if the staff should fail to provide you a receipt, please ask for one or notify our billing department at 530-872-6650.

I have read the financial policy and I understand and agree to the financial policy.

_____ _____

Patient/ Legal Representative Signature Date

Paradise Medical Group

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL INFORMATION

I authorize (**name of health care provider**)_____to use and/or disclose a copy of the specific health and medical information identified below for (**name of patient and DOB**)_____to (**name, address, telephone and fax number of recipient**) _____

_____

for the following purposes: (**describe each purpose of use / disclosure**) _____

_____

I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____Please send the entire medical record (all information) to the above named recipient.

_____All hospital records (including nursing records and progress notes)

_____Transcribed hospital reports

_____Medical records needed for continuity of care

_____Most recent five-year history

_____Emergency and urgent care records

_____Other:

_____Clinician office chart notes

_____Dental records

_____Laboratory reports

_____Pathology reports

_____Diagnostic imaging reports

_____Billing statements

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* The following items must be initialed to be included in the use and/or disclosure of other health information:

_____*HIV/AIDS related information and/ or records

_____*Mental health information and/ or records

_____*Genetic testing information and/ or records

_____*Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed) Describe: _____

_____

_____*Psychotherapy notes (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.

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I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

Unless revoked earlier, this authorization will expire 180 days from the date of signing or until (**insert applicable date or event**) _____

_____ _____

Patient/ Legal Representative Signature Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient

(A copy of this signed form may be provided to the patient.)

Paradise Medical Group

NOTICE OF PRIVACY PRACTICES
Paradise Medical Group

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

Paradise Medical Group *is committed to protecting your information and we encourage you the patient to contact our Privacy Officer in writing should any issue or question arise.*

Effective Date: April 14, 2003
This Notice was revised on March 10, 2021.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Walt Taber
Mailing Address: 6470 Pentz Road, Suite A
Telephone: 530-872-6650
Fax: 530-872-6653
Email: it@pmg-net.com

About This Notice
We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?
"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information
We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure 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, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. *(Optional, only included if applicable.)*

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data

set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

- **As Required by Law.** We will disclose Protected Health Information about you 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 Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that 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 Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is 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 and Opt Out

- **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 practicably can do so.

- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

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. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. 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. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

[Special Protections for HIV information, Alcohol and Substance Abuse information, Mental Health Information and Genetic Information.]

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. 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 or 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 a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

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 Request Amendments.** If you feel that the Protected 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 us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an 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.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends

involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. 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 do 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.

- **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 only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Paradise Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, (name and DOB of patient) _____ acknowledge and agree that I have received a copy of *Paradise Medical Group, Inc.'s* Notice of Privacy Practices.

_____ _____

Patient/ Legal Representative Signature Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Representative (if applicable) Relationship to Patient