

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

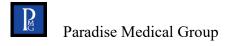
6470 Pentz Road Suite C Paradise, CA 95969

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

Ken Gillen, MS PA-C

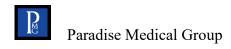
6470 Pentz Road Suite C Paradise, CA 95969

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



New Patient – Medical Information

Patient Name: First		Midd	lle	Last	
Date of Birth:/	/				
Who are your current m	nedical prov	viders?			
Provider name			Specialty, o	r condition for which they treat y	ou .
D C					
Preventive Care	l D /	1	l D .		D.
	Date	D	Date		Date
Annual physical		Prostate screen		Cholesterol test	
Colonoscopy		Pap screen		Diabetes screen	
Bone density		Mammogram		Eye exam	
Dental exam					
Immunizations					
IIIII WIII ZWIOII S	Date		Date		Date
Tetanus (Td or Tdap)	Bute	HPV (Gardasil)	Bate	Influenza (flu)	Buile
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		Other (please write below)	
COVID (brand/ type)		Simgles		emer (preuse write selew)	
(
Allergies or intolerances	s to medicat	tions?			
Name			Reaction		
Tunic			Reaction		
Please list all medication	ns, supplem	ents, over the counter	r drugs, crear	ns and inhalers.	
Name		Dose/Strength		Frequency taken	



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.

The state of the s							
	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 Med	lical	Histo	ory –	Plea	se ch	ieck	the a	ppro	pria	te bo	x if a	con	ditio	n is/v	vas p	rese	nt.			
	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																				



Paradise Medical Group

Would you like information or a copy of advance directive forms?

Social History												
Alcohol Use – Please circle your respo	nse.											
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 re	esponse.											
Sexually active? Currently Never Not Currently												
Sexual Partners?												
Birth control used? Pulling out Condom Diaphragm Implant Inserts IUD The Pill Patch Rhythm Spermicide Sponge Surgical Not applicable												
Drug Use – Please check your respons	e.											
□ None □ Amphetamines □ Benzodiazepines □ "Crack" Cocaine □ Cocaine □ Heroin □ Marijuana □ Methamphetamines □ PCP □ Huff Gasses □ Other												
Tobacco Use – Please check your resp	onse.											
☐ Smoke every day☐ Smoke some days☐ Second-hand exposure	☐ Former smoker	•		Heavy	smoke	r	□ Ligh	it smol	xer □	Never	smoke	d
How many packs/ day average?												
Have you ever chewed tobacco? □Yes □No)											
If you currently use any tobacco product(s), are yo	ou ready to quit?	es	□N	o								
Hospitalizations												
Reason	Year					(Comme	nts				
Major Injuries						1						
Туре	Year					C	omme	nts				
Advance Directives (Living will and medical power of attorney)												
Do you have an advance directive?												

 $\ \square \ Yes$

 $\; \square \; No$

	REVIEW OF SYSTEMS
haven't seen for a while, we need if you are not having any difficulties symptoms listed, PLEASE CIRCLI	ents who may be having a new problem, or our patients who we to update our records as to your general medical health. In each area is, please check "No Problems." If you are experiencing any of the E THE ONES THAT APPLY, or explain any that may not be listed. If please ask one of the technicians, or your doctor.
Const. (Health in General) weight loss, loss of appetite, fever, diagnosis of cancer. Other:	☐ No Problems Lack of energy, unexplained weight gain or night sweats, pain in jaws when eating, scalp tenderness, prior
Ears, Nose, Mouth & Throat nose, post-nasal drip, ringing in ea pain or numbness. Other:	☐ No Problems Difficulty with hearing, sinus problems, runny rs, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial
C-V (Heart & Blood Vessels) swelling of feet or legs, pain in legs	☐ No Problems Irregular heartbeat, racing heart, chest pains, s with walking. Other:
Resp. (Lungs & Breathing) cough, wheezing, sputum producti abnormal chest x-ray. Other:	☐ No Problems Shortness of breath, night sweats, prolonged on, prior tuberculosis, pleurisy, oxygen at home, coughing up blood,
	☐ No Problems Heartburn, constipation, intolerance to certain fficulty swallowing, nausea, vomiting, blood in stools, unexplained ce. Other:
GU (Kidney & Bladder) prostate problems, bladder problem	☐ No Problems Painful urination, frequent urination, urgency, ns, impotence. Other:
MS (Muscles, Bones, Joints) swelling of joints, joint deformities,	☐ No Problems Joint pain, aching muscles, shoulder pain, back pain. Other:
Integ. (Skin, Hair & Breast) in existing skin lesion, hair loss or	☐ No Problems Persistent rash, itching, new skin lesion, change increase, breast changes. Other:
	☐ No Problems Frequent headaches, double vision, weakness, n walking or balance, dizziness, tremor, loss of consciousness, visual loss. Other:
	☐ No Problems Insomnia, irritability, depression, anxiety, gs, hallucinations, compulsions. Other:
Endocrinologic (Glands)	☐ No Problems Intolerance to heat or cold, menstrual

irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:

frequent infections, exposure to HIV. Other:

☐ No Problems Easy bleeding, easy bruising, anemia, abnormal

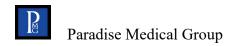
☐ No Problems Seasonal allergies, hay fever symptoms, itching,

Hematologic (Blood/Lymph)

Allergic/Immunologic

blood tests, leukemia, unexplained swollen areas. Other: ___

Today's Date: ___



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	e, Zip Code
Patient Physical Address		City, State	e, Zip Code
Patient Home Phone ()		Patient Mobile Pho	ne ()
Employment			
Employer name		Employer Phone ()
Usual occupation (current or	most recent)	Ţ	Usual industry
Legal Guardian			
Guardian Last Name		_ First Name	Middle name, suffix,
Guarantor			
Relationship to patient \square S	Self		
Guarantor Last Name		_ First Name	Middle name, suffix,,
Guarantor Date of Birth		_	
Guarantor Mailing Address _ □ Same as patient's		City, Stat	e, Zip Code
Guarantor Home Phone ()	_	Guarantor Mobile Phone () -



AUTHORIZATION REGARDING DISCLOSRES OF HEALTH INFORMATION

Patient Last Name		First Name	Date of birth	
I give Paradise Medical Gr voicemail for any and/or a			onfirm my appointments on my answe	ring machine or
I wish to enable to my Pati If yes, my email is				
Health Notifications Appointments Announcements Billing I give PMG authorization	□Email □Phone □Email □Phone □Email □Phone □Email □Phone □	□Text Message □Text Message □Text Message	·	
Obtain Medicatio	Immunization Reg n History Authority	istry) Consent □Yes □No r □Yes □No ny mobile phone □Yes □No		
time of an/all of my visits. \square Yes \square No			sentative(s) listed below to be in the exactive(s) listed below to have access to my	
I give PMG authorization t □Yes □No	to disclose to my fa	mily member(s) and/or legal	representative(s) listed below regarding	g my billing issues.
Family Member Legal Represent		Relationship	Phone Number	
Disclosures of Protected H set forth in PMG's HIPAA		o an individual's friend/famil	y member(s) must be made in accordan	ace with the procedures
This document does not ex	pire unless date is i	ndicated here:		
Patient/ Legal Representat	tive Signature		ate	_



Assignment of Benefits

Patient Last Name	F	irst 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							
I, (patient name) I hereby authorize a plan, to issue paym dependents regardle insurance. I hereby regarding my illnes (3) allow a photocoremain in effect unto behalf of myself and	ent check(s) directly to Paradise ess of my insurance benefits, if an authorize Paradise Medical Grous and treatments; (2) process insury of my signature to be used to il revoked by me in writing. I ha	hereby assign all medicare, property including Medicare, property Medical Group, Inc. for many. I understand that I among, Inc. to: (1) release any arance claims generated in process insurance claims we requested medical servand that by making this respective.	edical benefits to Paradise Medical Grovate insurance and any other health/memedical services rendered to myself and a responsible for any amount not covered information necessary to insurance cannot the course of examination or treatment for the period of lifetime. This order workies from Paradise Medical Group, Incequest, I become fully financially response	d/or my ed by rriers nt; and vill c. on						
Patient/Guarantor S	ignature	Date								



Patient/ Legal Representative Signature

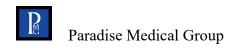
	FINANCIA	L POLICY
Patient Last Name	First Name	Date of birth/
Dear Patient,		
Thank you for choosing us as your h to establishing yourself as a patient.	ealth care provider. The following is a st	tatement of our Financial Policy, which we ask that you read and sign prior
Except as noted below, all charges i service is rendered.	ncurred for services in the office will be	e due and payable at the time
group contracts. However, all co-pay	s, deductibles and other appropriate pay	der Organizations and any other <i>Paradise Medical Group, Inc. (PMG)</i> rement responsibility per contract will be expected at the time of service. Iedi-Cal is not accepted as a primary insurance (accepted only as
		ir insurance coverage, or government regulations, you have agreed to be ice or your appointment may need to be rescheduled.
outstanding balance has not been pai	d in full the office manager will contact	nding balance of bills unpaid after 90 days from the date of service. If the you to arrange a payment plan. If the payment arrangement has not been u will be dismissed from Paradise Medical Group.
insurance company and receive payn to review insurance and personal bill	nent in a timely fashion. You must bring	with correct and accurate insurance information so that we may bill your gyour insurance card with you to each visit. At each visit you will be asked asked to verify that the information is correct. We will bill your insurance asyment.
Second Insurance: We will bill you	ir secondary insurance once.	
Payment Methods: We have a varie	ty of payment methods available includi	ing cash, check and credit card.
ultimately the responsibility of the pa	atient. We will need proof of workers co	ent for work-related injuries. Any charges incurred for this treatment are impensation coverage from your employer. Once we receive the appropriate our treatment. However, if they do not pay <i>you will be responsible</i> .
customary for our area. Except wher		tment for our patients and we set our fees according to what is usual and our insurance carrier, you are responsible for payment regardless of your ess.
Medicare Non-covered Procedures responsibility for payment.	: You are responsible for any non-cove	ered services requested and will be asked to sign a waiver form indicating
Refunds: If your accounts become of	overpaid, we will promptly refund the ov	verpayment due.
	checks received for payment of services processing charge of \$25.00 will be ch	s and returned by the bank marked "non-sufficient funds" will be charged to larged.
unless there is an emergency it is exp	pected that the patient will notify the phy	unable to make scheduled appointments due to emergencies. However, vsician's office within 24 hours of appointment and reschedule the led appointment three times in a row, a charge of \$50.00 will be added to
		ately. Our staff will always provide you a receipt for your payment. or notify our billing department at 530-872-6650.
I have read the financial policy and	l I understand and agree to the financ	cial policy.

Date



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 /								
I specifically authorize the use and/or disclosure of the fo	llowing health information and/or medical							
records, if such information and/or records exist:								
Please send the entire medical record (all info	ormation) to the above named recipient.							
All hospital records (including	Clinician office chart notes							
nursing records and progress notes)	Dental records							
Transcribed hospital reports	Laboratory reports							
Medical records needed for continuity	Pathology reports							
of care								
Most recent five-year history	Diagnostic imaging reports							
Emergency and urgent care records	Billing statements							
Other:								
* 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 red	cords							
*Mental health information and/ or records	3							
*Genetic testing information and/ or record	ds							
*Drug/alcohol diagnosis, treatment or refer	rral information (Federal regulations require a							
description of how much and what kind of information	on is to be disclosed) Describe:							
*Psychotherapy notes (If this authorization is for the	use and/or disalogura of navabathereny nates							
en it cannot be combined with any other authorization.	use and/or disclosure of psychotherapy hotes,							



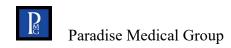
I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing 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 18 date or event)	0 days from the date of	of signing or until (insert applicable
Patient/ Legal Representative Signature	Date	
Print Patient's Name		
Print Name of Legal Representative (if applicable) (A copy of this signed form may be provided to the pa	 tient.)	Relationship to Patient



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 1	14, 2003	-	
This Notice was re	vised 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



Paradise Medical Group

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



Paradise Medical Group

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

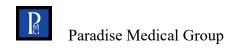
We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

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.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, (name and DOB of patient) received a copy of <i>Paradise Medical Group, Inc.'s</i> Notice	ce of Privacy Practices.	_ acknowledge and agree that I have
Patient/ Legal Representative Signature	Date	
Print Patient's Name		
Print Name of Legal Representative (if applicable)		Relationship to Patient