Coastline Orthopaedic Associates
a division of OrthoWest

Zafar S. Khan, MD
Payam Farjoodi, MD
Kathryn Perkins Tift, MD
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8700 Warner Avenue, Suite 140
Fountain Valley, CA 92708
(T) 714.850.7300
(F) 714.850.7310
www.coastlineortho.com

Patient Accident Questionnaire

Patient Name: _____ **Account Number**: _____

Was this accident work related? ***YES____ NO____

Was this accident a personal injury? ***YES____ NO____

Was this accident a motor vehicle injury? ***YES____NO____

If yes, is the claim outstanding? ***YES____ NO____

If not, when was it closed? _____

Is there a third party responsible? YES___ NO___

If yes, is the claim outstanding? YES___ NO___

If not, when was it closed? _____

Were you previously treated for this condition? YES___ NO___

If yes, please provide the following information:

Date and time of accident: _____

Location of accident: _____

Explanation on how accident happened, and injuries sustained:

_____

_____

_____

_____

***This office does not accept third party insurance. Please indicate the name(s) of your insurance company that will be responsible for this incident. <u>You will be responsible for all balance(s) due after your insurance paid and/or if your claim is denied</u>.**

1) _____

2) _____

Patient Signature: _____ **Date**: _____

FOR OFFICE USE ONLY: Employee initials: _____

Coastline Orthopaedic Associates

IF THIS CONDITION IS A RESULT OF A WORK INJURY, PLEASE DO **NOT** COMPLETE THIS FORM. PLEASE NOTIFY OUR FRONT OFFICE ASSISTANT

PATIENT'S PERSONAL INFORMATION

Sex: MALE FEMALE (CIRCLE ONE)

Legal Name: _____ _____ _____
LAST NAME FIRST NAME MI

Street Address: _____ City: _____ State: _____ ZIP: _____

Marital Status: Single • Married • Divorced • Widowed (CIRCLE ONE) Spouse's Name: _____ _____
LAST NAME FIRST NAME

Home Phone: ( ) _____ Cell Phone: ( ) _____ Driver's License #: _____

E-mail: _____ Date of Birth: _____ Age: _____ Social Security #: _____

Reason for today's visit: _____

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Social Security # _____

Responsible party's home phone: ( ) _____ Work phone: ( ) _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Employer's Name: _____ Phone Number: ( ) _____

Occupation: _____ Supervisor: _____

Spouse's Employer's Name: _____ Phone Number: ( ) _____

Street Address: _____ City: _____ State: _____ ZIP: _____

INSURANCE INFORMATION

Name of Insured: _____ Relation to Insured: _____ DOB: _____

PRIMARY Insurance: _____ Deductible $ _____ Deductible Met? Y N

Primary Insurance ID number: _____ Primary Insurance Group Number: _____

Insurance Billing Address: _____ City: _____ State: _____ ZIP: _____

SECONDARY Insurance: _____ Your Relation to Insured: _____ DOB: _____

Insurance Billing Address: _____ City: _____ State: _____ ZIP: _____

Secondary Insurance ID number: _____ Secondary Insurance Group Number: _____

PATIENT'S REFERRAL INFORMATION

Who may we thank for referring you? _____

Is this visit the result of an accident/injury? ___Yes __No If yes, please give us the approximate date: _____

Name of your family physician: _____ Family Physician's Phone Number: ( ) _____

Have you been seen by one of our physicians before? ___Yes__No If yes, please give us the approximate date: _____

Do you have any ALLERGIES? ____Yes ____No If yes, please list: _____

EMERGENCY CONTACT INFORMATION

Name of person NOT living with you: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Phone Number (Home): ( ) _____ Phone Number (Work): ( ) _____

Consent to Examination • Authorization to Release Information • Assignment of Benefits • Financial Agreement

I hereby authorize the above physician to perform an orthopedic consultation and examination, and to initiate diagnostic and therapeutic treatments that may be considered advisable or necessary. I hereby authorize the above physician to release to the insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby give lifetime authorization for payment of insurance benefits to be made directly to the physician rendering service. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize these physicians to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____ *Employee Initials:* _____

Medical History Information

Please fill out every section. If none apply, please check **NONE**. Thank You.

Patient Name: _____ Date of Birth: _____

Patient Height: _____ Patient Weight: _____ Gender: MALE | FEMALE

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

---

Pharmacy Information

Preferred Pharmacy: _____

Pharmacy Address or Cross Streets and City: _____

Pharmacy Phone Number: _____

Past Medical History

- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Arrhythmia
- ☐ Coronary Artery Disease
- ☐ Pacemaker
- ☐ Cancer Type: _____
- ☐ Diabetes Type: _____
- ☐ Hepatitis Type: _____
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Neuropathy
- ☐ Seizures
- ☐ Stroke
- ☐ COPD
- ☐ DVT (Deep Vein Thrombosis)
- ☐ Other: _____
- ☐ **NONE**

Past Surgical History

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Breast Augmentation
- ☐ Breast Biopsy
- ☐ Gallbladder Removed
- ☐ Hysterectomy
- ☐ Ovaries Removed
- ☐ Kidney Removed
- ☐ Mastectomy ( )Left ( )Right
- ☐ Prostate Biopsy
- ☐ Other: _____
- ☐ **NONE**

Orthopaedic History

- ☐ Bursitis
- ☐ Epidural Injections (Spine)
- ☐ Fracture Type: _____
- ☐ Carpal Tunnel Syndrome
- ☐ GOUT
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ RSD (Reflex Sympathetic Dystrophy
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Cervical Spinal Stenosis
- ☐ Lumbar Spinal Stenosis
- ☐ Vertebral Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Other: _____
- ☐ **NONE**

Medical History Information

Please fill out every section. If none apply, please check **NONE**. Thank You.

Orthopaedic Surgical History

- ☐ Ankle Surgery ( )Left ( )Right
- ☐ Knee Arthroscopy ( )Left ( )Right
- ☐ ACL Reconstruction
- ☐ Shoulder Arthroscopy
- ☐ Carpal Tunnel Decompression
- ☐ Cervical Spine ( )Fusion ( )Decomp
- ☐ Lumbar Spine ( )Fusion ( )Decomp
- ☐ Intramedullary Nailing Femur/ Tib/Fib
- ☐ Hip Replacement ( )Left ( )Right
- ☐ Knee Replacement ( )Left ( )Right
- ☐ Shoulder Replacement ( )Left ( )Right
- ☐ Trigger Finger Release ( )Left ( )Right
- ☐ Other: _____
- ☐ **NONE**

Current Physicians

- ☐ Primary Care Physician: **Name/Phone**_____
- ☐ Pediatric: **Name/Phone**_____
- ☐ Cardiologist: **Name/Phone**_____
- ☐ Pain Management: **Name/Phone**_____
- ☐ Physical Therapy: **Name/Phone**_____

Medications

*MUST PROVIDE **ALL** MEDICATION CURRENTLY TAKING*

_____
_____
_____
_____
_____
_____

- ☐ **Separate list provided**
- ☐ **NONE**

Allergies to Medications

_____
_____
_____
_____
_____
_____

- ☐ **Separate list provided**
- ☐ **NONE**

***If you have a medication list, please hand it to the Receptionist or Medical Assistant so it can be scanned into your chart.**

Social History

Occupation: _____

Tobacco Use: ☐ Yes ☐ No

Alcohol Use: ☐ Yes ☐ No

Claustrophobic: ☐ Yes ☐ No

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Payment Policy

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

Missed Appointments – Our policy is to charge for missed appointments not canceled within 24 hours of time for regular office visits and within 7 days' notice for scheduled surgeries. These charges will be your responsibility and billed directly to you. **This charge is not covered by your insurance.** Please help us to serve you better by keeping your regularly scheduled appointment.

Our charges are as follows:

Office Visit	$50.00
Surgery	$250.00

Form Completion – There may be a charge of $25.00 to $50.00 for each form a patient may request us to complete such as: DMV forms, Assisted Living forms, health assessments, letter(s) to third parties, etc. If forms or reports are lengthy, charges may be higher depending on the amount of time spent on completion. **This charge is not covered by your insurance.** Please allow 72 hours for completion of forms.

Co-payments and Deductibles – All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Return Check Charge – All accounts with checks returned from the bank for any reason will be assessed $25.00 per returned check.

Insurance – We participate in most insurance plans, including Medicare, Monarch, Greater Newport and Memorial Care, among others. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Verification of insurance or authorization is not a guarantee of payment. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Non-Covered Services – Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of Insurance – All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission – We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. After the initial billing, the patient must assume responsibility in collecting from the insurance company.

Coverage Changes – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment – Patient responsibility is due 15 days upon receipt of billing statement. In the event of late or nonpayment of any portion of patient responsibility you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be responsible for all outstanding balances, including any collection agency fees accrued. As a result, you and your immediate family members may be discharged form this practice. If this occurs, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Prescriptions – All prescriptions refills should be requested prior to 4:30pm, Monday – Friday. We do not approve refill prescriptions during off hours.

Medical Records – Copies of your medical records are available upon request for a $25.00 fee. Please allow 5 working days from receipt of your payment for the records.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

I have read and understand the policy and agree to abide by its guidelines.

Patient Name (Print): _____

Signature: _____ **Date**: _____

FOR OFFICE USE ONLY: Account #: _____ ***Employee Initials:***_____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I (print name),_____understand that as part of my healthcare, Coastline Orthopaedic Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided,
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to object to the use of my health information for directory purposes; and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Coastline Orthopaedic Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Coastline Orthopaedic Associates reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Coastline Orthopaedic Associates change their notice; they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).
I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures by fax.

Will anyone else be involved in the choices and decisions you will make regarding your surgical procedure, or in any discussions with the doctor or staff following your surgical procedure? ____YES / ____NO

If yes, please specify: Name:_____Relationship:_____

If I choose to involve anyone else in my choices, decision-making, or in any evaluation or comment on my results, I will be personally responsible for providing that person a copy of the doctor's documents, informed consent documents, operative consent forms, and implant manufacturer's information (if applicable). Further, I will encourage that person to read the documents in detail so that we reach a common understanding and acceptance of choices, risks, and tradeoffs prior to my surgery. Lastly, I will invite and encourage that person to participate in all of my consultations with my patient educator (in person or by phone) and in person for my consultation with the doctor. I understand and accept that I alone am ultimately responsible for the decisions I make and the requests I make. If I involve anyone else in my decisions, it is my responsibility alone to reconcile their wishes and thoughts with what I choose for my own body. The doctor will rely solely on my written requests that I complete during my education and consultation process, and any other person's input must be included in my written requests prior to surgery. Prior to surgery, I alone am responsible for making my choices and decisions. Following surgery, I alone am responsible for my choices and decisions, and I alone will discuss any concerns I have with the doctor and his staff.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient Signature **Date**

FOR OFFICE USE ONLY

□ Consent received by: _____ □ Consent refused by patient □ Consent added to the patient's medical record on: _____

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

NOTIFICATION TO CONSUMERS
MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE
MEDICAL BOARD OF CALIFORNIA
(800) 633-2322
www.mbc.ca.gov
PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY THE PHYSICIAN ASSISTANT COMMITTEE
(916) 561-8780
www.pac.ca.gov

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Signature: _____ **Date**: _____

FOR OFFICE USE ONLY: Account #:_____ **Witness:**_____

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Acknowledgment of Privacy Notice Practices

Privacy Office – Office Manager (714) 850-7300

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amend Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amend Notice of Privacy Practices by E-Mail at:

E-Mail: _____

Signature: _____ **Date: _____**

Print Name: _____ **Telephone: _____**

****

If not signed by the patient, please indicate relationship:

☐ **Parent or guardian of minor patient**

☐ **Guardian or conservator of an incompetent patient**

Patient Name: _____

Patient Address: _____

_____

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NARCOTIC POLICY

Please note that this office only prescribes narcotic pain medications (this includes any medication containing Codeine, Hydrocodone, Oxycodone among others) to patients who have had surgery. In addition, these prescriptions can only be provided for 90 days after surgery.

- ✓ Prescriptions will not be filled for unauthorized "walk-in" patients. Patients must phone their pharmacy.
- ✓ No medication/prescription will be replaced if lost, stolen, misplaced, overused, etc.
- ✓ Any further medication needs will need to be met by either your primary medical doctor or a pain specialist.
- ✓ If you require longer term pain therapy either before or after surgery, please notify your provider and we will refer you to an appropriate pain management specialist.
- ✓ Please call your pharmacy directly to refill prescriptions that are filled locally. They will contact us for a refill authorization.

I understand and accept the protocol listed above. Failure to comply may subject immediate termination of prescriptive medications.

Print Name: _____ Date: _____

Signature: _____

We strive to offer the best services and care for each patient in a timely manner. The above "rules" are essential and necessary to efficiently manage a busy clinic. Thank you in advance for your cooperation and understanding.

NOTICE OF PRIVACY PRACTICES

Coastline Orthopaedic Associates
8700 Warner Ave., Suite 140
Fountain Valley, CA 92708
Privacy Officer: 714.850.7300

Effective Date: January 1, 2023

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may also use our text messaging application to leave messages directly to the phone provided.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. **Fundraising**. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications**. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. **Right to an Accounting of Disclosures**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.
After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. **We will also post the current notice on our website: coastlineortho.com**

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Region IX
Office for Civil Rights
U.S. Department of Health & Human Services 90 7th Street, Suite
4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.