ARROYO MEDICAL GROUP, INC.

Dewey S. Sandberg, M.D. ~ David Ruiz, M.D.
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Megan M. Malzone, M.D. ~ Mary Lowery, M.D.
Marisa Ayers, PA-C ~ Jennifer Owen, MPAS, PA-C

TO: _____

_____

An appointment has been scheduled for you on _____ at _____ with _____. Please arrive at _____. Please notify us as soon as possible if you are unable to keep this appointment.

Arroyo Medical Group, Inc.
931 Oak Park Blvd., Ste. 101
Pismo Beach, CA 93449
(805) 474-2600

We respect your time and would like to make your visit to our practice as efficient and helpful as possible. To assist with this, we would appreciate it if you would complete the enclosed information sheet and medical history form ahead of time and **bring them with you**, along with your medical insurance information, when you come for your appointment. Please **bring all of your current medications** and, if possible, names and addresses of your previous doctors and hospitals so that we may send for your previous medical records if necessary.

We are also enclosing information on Arroyo Medical Group and our office policies for you to read. We hope this information will be helpful to you. If you have any questions or if we can be of further assistance, please call our office at (805) 474-2600.

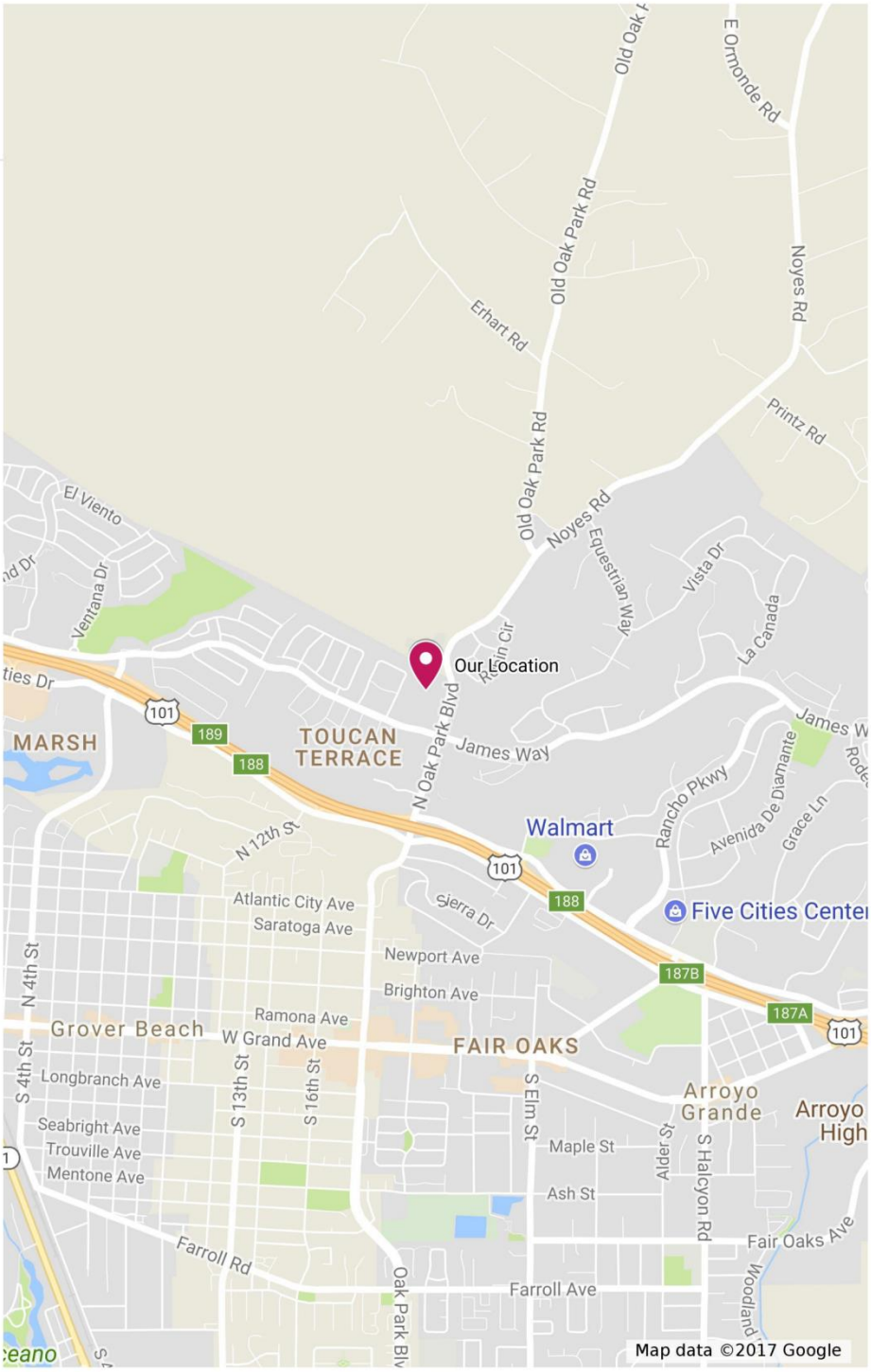
We look forward to meeting you.

The Physicians and Staff of Arroyo Medical Group

Arroyo Medical Group

931 N Oak Park Blvd, Ste 101,
Pismo Beach, CA 93449

Our Location



ARROYO MEDICAL GROUP, INC.

NEW PATIENT INFORMATION AND UPDATE (ADULT)

PLEASE PRINT

NAME _____ AGE: _____
(LAST) (FIRST) (MI)

BIRTH DATE:_____ SOCIAL SECURITY #:_____ DRIVER'S LICENSE #_____

SEX: ❑ MALE ❑ FEMALE

MARRIED ❑ SINGLE ❑ WIDOWED ❑ CELL #:_____ HOME PHONE #:_____

MAILING ADDRESS: _____
P.O. BOX OR STREET CITY STATE ZIP CODE

STREET ADDRESS:_____
(IF DEFFERENT FROM MAILING ADDRESS) STREET CITY STATE ZIP CODE

PATIENT'S OCCUPATION: _____ WORK PHONE #:_____

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

SPOUSE NAME: _____ OCCUPATION: _____WORK PHONE #:_____

SPOUSE'S EMPLOYER:_____

SPOUSE EMPLOYER'S ADDRESS:_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?

_____
NAME PHONE # ADDRESS RELATIONSHIP TO PATIENT

<u>INSURANCE INFORMATION</u>

WE WILL BILL YOUR INSURANCE AS A COURTESY, PROVIDED YOU SUPPLY US WITH THE INFORMATION NECESSARY TO DO SO. IF YOU DO NOT WANT US TO BILL ANY INSURANCE FOR YOU, PLEASE CHECK HERE ❑

<u>PLEASE BRING YOUR INSURANCE IDENTIFICATION CARD(S) WITH YOU TO EACH OFFICE VISIT.</u>

INSURANCE COMPANY:_____
(PRIMARY) NAME ADDRESS

PATIENT ID# _____ GROUP # _____

INSURANCE COMPANY _____
(SECONDARY) NAME ADDRESS

PATIENT ID# _____ GROUP # _____

SUBSCRIBER RELATIONSHIP TO
NAME OF SUBSCRIBER:_____ BIRTH DATE:_____PATIENT:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:

I hereby authorize Arroyo Medical Group, Inc. to release to my insurance company any information acquired in the course of my treatment necessary to process my claim. I authorize payment of benefits directly to Arroyo Medical Group, Inc., otherwise payable to me.

I agree to be financially responsible for all services provided to me, including all insurance co-payments, deductibles, and charges not covered by my insurance contract.

_____ _____
TODAY'S DATE SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE)

ARROYO MEDICAL GROUP, INC.

NEW PATIENT INFORMATION AND UPDATE (ADULT)

PHARMACY INFORMATION

PHARMACY #1 LOCAL

PHARMACY NAME _____

PHARMACY ADDRESS_____

PHARMACY #3 MAIL ORDER/90 DAY SUPPLY

PHARMACY NAME_____

PHARMACY ADDRESS_____

COMMUNICATION PREFERENCES

Please indicate your preferred method of communication. While we will contact you using your preferred method, in an urgent situation, we may use any of your contact numbers.

❑ **TEXT MESSAGE TO CELL** ❑**HOME PHONE ONLY** ❑**CELL PHONE ONLY** ❑**PATIENT PORTAL**

❑**EMAIL** ❑**OTHER**

ARROYO MEDICAL GROUP, INC.
931 OAK PARK BOULEVARD, SUITE 101
PISMO BEACH, CA 93449

PATIENT'S INFORMATION	
NAME (Last, First, Middle)	BIRTHDATE
LOCAL PHARMACY (Name, Address, Phone Number)	MAIL ORDER PHARMACY (Name, Address, Phone Number)

REASON FOR VISIT	
Patients Injury/Illness: 1. 2. 3.	Onset Date: _____ Rate of Pain(0= no pain; 10= most severe) 1 2 3 4 5 6 7 8 9 10

ALLERGIES (Medication(s), Environmental Issue(s), and Food(s))	
Item(s) that you are *allergic* to:	Reaction(s) you have had from the *Allergen,* you are allergic to:

MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS			
Drug Name (Brand name, or generic name)	Dosage	Times taken within 24 Hours	Reason for taking Medication

REVIEW OF SYSTEMS: Please check boxes that apply for today's visit.

CONSTITUTIONAL:
- □ Chills
- □ Fatigue
- □ Fever
- □ Malaise
- □ Night Sweats
- □ Weakness
- □ Weight Gain
- □ Weight Loss

HEAD, EYES, EARS, NOSE, AND THROAT:
- □ Ear drainage
- □ Ear pain
- □ Eye discharge
- □ Eye pain
- □ Hearing loss
- □ Nasal drainage
- □ Sinus pressure
- □ Sore throat
- □ Eye Redness

RESPIRATORY:
- □ Chronic cough
- □ Cough
- □ Known TB exposure
- □ Shortness of breath
- □ Wheezing

CARDIOVASCULAR:
- □ Chest Pain
- □ Calf pain
- □ Swelling
- □ Palpitations

GASTROINTESTINAL:
- □ Abdominal Pain
- □ Blood in stools
- □ Change in stools
- □ Constipation
- □ Diarrhea
- □ Heartburn
- □ Loss of appetite
- □ Nausea
- □ Vomiting

GENITOURINARY:
- □ Burning with urination
- □ Blood in urine
- □ Frequent urination
- □ Urinary incontinence
- □ Urinary retention

WOMEN:
- □ Abnormal PAP
- □ Painful periods
- □ Painful intercourse
- □ Hot flashes
- □ Irregular periods
- □ Vaginal discharge

MEN:
- □ Impotence
- □ Reduced libido
- □ Reduced stream
- □ Nighttime urination

INTEGUMENTARY (SKIN):
- □ Brittle hair
- □ Brittle nails
- □ Rash
- □ Hives
- □ Skin Lesion
- □ Itching

NEUROLOGICAL:
- □ Dizziness
- □ Numbness
- □ Extremity weakness
- □ Gait disturbance
- □ Headache
- □ Memory loss
- □ Seizures
- □ Falls

PSYCHIATRIC:
- □ Anxiety
- □ Depression
- □ Insomnia
- □ Bipolar disorder

METABOLIC/ENDOCRINE:
- □ Cold Intolerance
- □ Heat Intolerance
- □ Excessive thirst
- □ Hot Flashes

MUSCULOSKELETAL:
- □ Back pain
- □ Joint pain
- □ Joint swelling
- □ Muscle weakness
- □ Neck pain
- □ Muscle pain
- □ Muscle cramps

HEMATOLOGIC:
- □ Easy bleeding
- □ Easy bruising
- □ New lumps or bumps

IMMUNOLOGIC
- □ Contact allergy
- □ Environmental allergies
- □ Food allergies
- □ Seasonal allergies

ARROYO MEDICAL GROUP, INC.

PATIENT INFORMATION

NAME (Last, First, Middle)	BIRTHDATE

CHRONIC PROBLEM LIST

Chronic Problem	Onset Date

PAST MEDICAL/SURGICAL HISTORY

Procedure	Year

FAMILY HISTORY (Please List only Mother, Father, Brother, and Sister)

□ PATIENT ADOPTED

□ NO RELEVANT FAMILY HISTORY

Diagnosis	Family Member	Age Onset	If deceased, age at death	Comments

SOCIAL HISTORY

TOBACCO USE:

Uses Tobacco: □ Currently □ Formerly
□ Never □ Unknown

Type: □ Chewing □ Cigar □ Cigarettes
□ Pipe □ Smokeless □ Snuff

Units/Day: _____

Years Used: _____

Occupation:

_____

Full time/part time/retired:

_____

Marital Status: _____

Number times pregnant_____Live Births_____
Induced Abortions_____Miscarriages_____

Number of Children: _____

Daughters:_____ # Sons _____

ALCOHOL USE:
□ Yes □ No
□ Formerly - Year Quit _____

If "YES" –
Type of Alcohol
_____

Frequency _____

When was Last Drink _____

DRUG USE:
□ Yes □ No

Type: _____

Amount used: _____

CAFFEINE USE:
□ Yes □ No

Type _____

Amount Daily _____

SPECIALISTS / CONSULTANTS		SPECIALISTS / CONSULTANTS	
Name	Specialty	Name	Specialty

WHEN WAS YOUR LAST:

Immunizations:

Flu Vaccine _____
Hepatitis A_____
Hepatitis B_____
Human Papilloma Virus (HPV) _____
Meningococcal B_____
Pneumococcal, PPSV23 or Pneumovax23® _____
Pneumococcal, PCV13 or Prevnar 13®
_____
Shingles, Zostavax _____
Tdap (tetanus/dipth/Pertussis) _____
Td or DT (tetanus/diphtheria)_____
TB Skin Test (PPD) _____

Diagnostic Procedures:

Eye Exam _____
Mammogram _____
DEXA (Bone Density Study)_____
PAP Smear _____
Stool Blood Test _____
Colonoscopy _____
EGD (Upper Endoscopy)_____
PSA _____
Chest Xray _____
Pulmonary Function Test _____
EKG _____
ECHO _____
Treadmill _____
Angiogram/Cath _____
CT Scan _____
MRI Scan _____
Aortic Ultrasound _____
Carotid Ultrasound _____
IVP(Intravenous Pyelogram)_____
Gallbladder Sonogram _____

_____ _____ _____
Patient's Printed Name Patient's Signature Date Signed

The State of California requires every patient be advised of

The following:

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the

Medical Board of California

(800) 633-2322

www.mbc.ca.gov

Patient Name:_____

Patient Signature:_____

Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Arroyo Medical Group, Inc.
Privacy Officer – (805) 474-2626

I hereby acknowlege 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 I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Print Name:_____ Date:_____

Signature:_____ Phone #:_____

If not signed by the patient, please indicate relationship:

- ❑ Parent or Guardian of minor patient
- ❑ Guardian or Conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient:_____

Financial Information

This information is to help you understand your financial obligations to your physician.

GENERAL INFORMATION:

- Arroyo Medical Group, Inc. will accept cash, personal checks, MasterCard and Visa.
- Current insurance and identification cards are required. If there are any changes to your insurance, please present your new card at the time of your appointment.
- We do not bill tertiary (third) insurance companies.
- Arroyo Medical Group, Inc. encourages you to become familiar with your health insurance plan and its benefits. Any balance unpaid by your insurance company is your responsibility.
- To protect you from imposters, your photo will be taken and kept on file.
- Arroyo Medical Group, Inc. will suggest specialists or testing based on medical necessity. It is your responsibility to find labs and specialists that will accept your insurance. Please call your insurance company or the specialist to whom we refer you with any questions about coverage.

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES:

- Co-Payments will be collected at the time of your visit.
- If we know the amount of your co-insurance, it will be due at the time of your visit; we will collect the amount at that time. Otherwise, you will be required to pay your co-insurance within 15 days of receiving your statement from our office.
- If you have not met your deductible when your medical services are provided, you will be expected to pay your deductible at the time of service.

SELF-PAY:

- If you do not have health insurance, payment will be collected at the time of service.
- In some cases, you may make arrangements with our Business Office to make payments. Please contact the Business Office at (805) 474-2618 for more information and to arrange payments.

MEDICARE:

- If you are a Medicare beneficiary with Part B insurance, we will file your claim with Medicare.
- Payments for services not covered by Medicare will be collected at the time of your visit.

NON-CONTRACTED PLANS:

- If you are covered by an insurance company that Arroyo Medical Group, Inc. is not contracted with, and you wish to schedule with our physicians, payment will be collected in full at the time of service. We will bill your insurance company as a courtesy, and the insurance company may reimburse you directly in accordance with their rates.

NON-COVERED BENEFITS:

- Certain professional services may not be covered by health plans and are billed at a cash rate. The following are samples of non-covered services and prices. Please ask in advance about your specific form, letter, or service for a quote of the cost to complete it.

- Physical Forms	$25 and up
- Jury Duty Excuses	$25 and up
- School Medication Forms	$25 and up
- Original Disability Forms	$50 and up
- Letters (any reason)	$25 and up
- Continuation of Disability Forms	$25 and up
- DMV Handicapped Placard	$25 and up
- Conservatorship Forms	$100 and up
- DMV Long Forms	$50 and up
- Original Board and Care Forms	$50 and up
- Assisted Living Forms	$50 and up
- Insurance Sickness Claim Forms	$25 and up
- Work Related Forms	$50 and up
- Life Insurance Forms	$50 and up
- Lost Prescriptions	$10 per medicine
- Lost Prescriptions (Schedule II)	$12 per medicine

Prices are subject to change. These charges are in addition to any evaluation by a physician.

AUTO ACCIDENTS AND PERSONAL INJURIES:

- If your problem is due to an auto accident or other injury, please let us know immediately so that the correct insurance information may be generated for you. As your injuries may be insured by insurance companies with whom we are not providers, payments for medical care in our office are due at the time services are rendered. We will submit an insurance claim for you, and your insurance company may reimburse you directly.
- For a fee of $0.25 per page, we can provide you with the copies of reports and paperwork required.
- We do not accept liens or letters of protection.
- If you prefer to see a different physician for your auto accident or personal injury claim, we will still see you for other medical needs.

WORKERS COMPENSATION:

- Worker's Compensation is defined as any condition which results from, or is aggravated by your job. Your regular insurance does not cover this condition.
- Our Practice does not provide care for Worker's Compensation cases. Ask your employer for a referral to a Worker's Compensation clinic.

PREVENTIVE HEALTH EXAMS:

- Routine physicals, annual exams and check-ups are examples of preventive health and will be categorized as such on any claims submitted to your health plan.
- Many plans, including Medicare, may not cover preventive visits. If you are unsure about coverage for an upcoming exam, please contact your health plan.
- **Claims will not be altered in any way once they are filed and verified to be accurate**. You will be responsible for any charges not covered by your health plan.

MISSED APPOINTMENTS AND LATE CANCELLATIONS:

- Though our office attempts to contact patients to confirm upcoming appointments, it is the patient's responsibility to manage his/her schedule and to keep appointments.
- If you need to cancel or reschedule, please contact us at least 24 hours before your scheduled appointment.
- If you have multiple no shows, you will be subject to dismissal

DELINQUENT ACCOUNTS:

- If a patient has an unpaid balance that remains unpaid for 60 days, patients will receive a notice from our Business Office. If the balance continues to go unpaid and no arrangements are made to make payments, the account will be sent to a collection agency.

RETURNED CHECKS:

- Any returned check will result in a $25 service fee. Returned checks must be redeemed with cash or credit card within 14 days of being returned, or the account will be considered delinquent.
- Two returned checks within a 12-month period will place a patient's account on a cash-only status.
- If we receive a check from a closed bank account, we will submit it to the District Attorney's office.

- I HAVE READ AND UNDERSTAND THIS BINDING FINANCIAL DOCUMENT AND AGREE TO ITS TERMS.
- I UNDERSTAND THAT CHARGES NOT COVERED BY MY HEALTH PLAN ARE MY RESPONSIBILITY.
- I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO ARROYO MEDICAL GROUP, INC. WHENEVER NECESSARY. I AUTHORIZE ARROYO MEDICAL GROUP, INC. TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY TO FACILITATE PAYMENT OF A CLAIM.
- ALL QUESTIONS ABOUT THIS FINANCIAL DOCUMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____

Patient's Name (PLEASE PRINT) Date

_____

Signature of Patient or Responsible Party

Authorization for Use or Disclosure of Protected Health Information

Arroyo Medical Group, Inc. Privacy Officer (805) 474-2626 Fax (805) 270-4752

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California Law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. I hereby authorize this medical practice to receive and use health information concerning:

_____

(patient name and address)

From:_____

(name and address of facility from which records will be obtained)

Health information to be received and used:

Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the *Lanterman-Petris-Short Act*, drug and/ or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

_____

This health information may be disclosed to:

Arroyo Medical Group 931 Oak Park Blvd., Ste. 101 Pismo Beach, CA 93449

(name and address of person to use or receive health information)

The information may be used for the following purposes (if you do not wish to explain, write "at the request of the individual") _____

This authorization will expire exactly one year from the date below. I understand that I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt. I have the right to receive a copy of this authorization. The health care provider will not condition the provision of care or receipt of benefits upon signing this authorization. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse under California law, all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that I may be charged for copies provided.

Signature:_____ Date:_____

Signed by: Patient_____ Guardian_____ Conservator_____

Date of Birth:_____

Welcome to Arroyo Medical Group, Inc.

Thank you for choosing the physicians of Arroyo Medical Group for your medical care. This notification provides an opportunity to explain important features of our medical practice. You may wish to keep this information as a reference for questions that may arise.

APPOINTMENTS:
Office visits are by appointment only. When you call for an appointment, our reception staff will ask a few questions regarding the nature and urgency of your problems or concerns. For routine health care, please call several days in advance. We always try to accommodate you if you have a physician preference; however, if your chosen physician is unavailable, we may need to arrange for you to see another Arroyo Medical Group Physician or Physician Assistant.

OFFICE HOURS:

Monday – Friday	8:30 a.m. – 12:30 p.m.
	1:30 p.m. – 5:00 p.m.

If you are unable to keep your scheduled appointment, we ask that you let us know at least 24 hours before your scheduled appointment time. This allows the time saved for you to be used by another patient.

EMERGENCIES:
In case of an emergency, when the situation is obviously critical or life threatening, go directly to the nearest hospital emergency room or call 911. The emergency room staff will inform us of your arrival. If you need to speak to our physician on call, outside of office hours, please call our main telephone number **(805) 474-2600** and the answering service will forward the call to the doctor on call. One of our physicians is available 24 hours a day, every day of the year. If yours is not a serious problem or an emergency, please wait until regular office hours to contact us.

OFFICE PHONE NUMBERS:
Our main telephone number is (805) 474-2600. If your call is answered by our automated system, it will be necessary for you to select an option in order for your call to be transferred.

TRANSFER POLICY:
It is the policy of Arroyo Medical Group, Inc. that a patient who leaves the practice cannot be reassigned to another physician in the Group.

TELEPHONE CALLS DURING OFFICE HOURS:

Arroyo Medical Group receives over 1,500 calls per day. Our staff returns calls according to their urgency, time of receipt, and what is happening in the clinic. This will generally be at the end of office hours in order to not disrupt the physicians' time while caring for patients with scheduled appointments. Please convey your questions and concerns clearly if you reach the Physician's or Medical Assistant's voicemail. Your call will be returned as soon as reasonably possible.

PRESCRIPTION REFILLS:

Please call your pharmacist at least two days ahead of time when you require a refill on your medication(s). This allows time for the pharmacist to check with your physician regarding renewal of the prescription.

HEALTH MAINTENANCE:

We offer all patients continuing and comprehensive health care. We encourage patients to prevent health problems and assist us in detection of disease at its earliest stage. This requires routine examinations and periodic visits. Your physician will discuss a personal health maintenance program with you following your initial visit and tests.

MEDICAL FEES:

Medical costs are increasing at a rapid rate and we are making every effort to keep fees reasonable. In order to contain costs by decreasing paperwork and personnel time, **we do require payment for your care at the time a service is rendered**. If your insurance plan has a co-payment or co-insurance, we will be requesting that payment be made on the day of your visit. This may require our Business Office to call your insurance company regarding any deductible you may have associated with your visit. If you are unable to pay for your care, please make arrangements with our Business Office staff before your visit.

INSURANCE BILLING:

Arroyo Medical Group Physicians accept almost all major insurances, but only accept a few Managed Care Plans (HMOs). We accept assignment with Medicare and will bill all secondary plans after Medicare has processed your claim. We do not accept any Medicare Advantage plans except "Physicians Choice". Regardless of your insurance, payment remains your personal responsibility. Credit bureau action may be taken on accounts more than 60 days past due. Please bring your insurance card with you on each visit and inform us if your insurance coverage changes.

PRIMARY CARE, ARROYO MEDICAL GROUP, AND YOU

With the rapid changes in health care delivery, health insurance, and technological advances in the United States, the concept of a doctor who oversees your healthcare is sometimes being lost. Arroyo Medical Group was formed to provide patients with up-to-date medical advice, preventive care, continuity of care, and coordination of patients' various medical needs. The doctors at Arroyo Medical Group are not "general practitioners", but rather Specialty Board Certified in either Family Practice or Internal Medicine with at least two extra years of training and periodic recertification in treating the whole patient.

Patients sometimes wonder why they need a "Primary Care" doctor if they are seeing other specialists. The answer is simple: The specialist takes care of his or her area of expertise, but not the whole patient. Many specialists will not see a patient unless they also have a Primary Care doctor, as they do not want just part of the patient's health care issue addressed.

Patients sometimes ask why they need to see their Primary Care doctor if they are feeling fine. The major reason is that serious diseases, such as hypertension, cancers, high cholesterol, diabetes, and many others often start with no symptoms at all. Immunization updates and lifestyle changes can also be addressed at these "well visits". Like most problems in life, medical issues are best handled by prevention or early treatment.

At Arroyo Medical Group, we believe that excellent medical care can only be delivered if periodic assessments of your condition are done. However, we also understand that some patients may have reason why they just wish to have episodic care – seeing a doctor only when something goes wrong. We respect the right of those patients to choose their plan of care, but Arroyo Medical Group does not follow patients for episodic care. As per national guidelines for preventive care, patients over 40 years of age should expect to be seen at least once per year for a preventive examination (also known as a "physical") to address these needs. Those with chronic medical problems will generally need to be seen more often as determined by their doctor. If a patient is not seen within a 3-year period, they are no longer considered patients of Arroyo Medical Group. Arroyo Medical Group's mission is to maximize your health and decrease your long-term health care expenditures. We look forward to working together with you on this.

Notice of Privacy Practices – Effective January 1, 2013

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review this notice carefully. If you have any questions, you may contact our office at (805) 474-2600. We are required by law to maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you (Health Information or PHI). Except for the following purposes, we will use and disclose Health Information only

with your written permission. You may revoke such permission at any time by stating, in writing, that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. We may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party. For example, we may give your health plan information in order that they will pay for your treatment. However, if you pay for your services yourself and without any third party contribution or billing, we will not disclose Health Information to a health plan if you instruct us not to do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. Subject to the exception above if you pay for your care yourself, we also may share information with other entities (for example, your health plan) that have a relationship with you for their health care operations.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an upcoming appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services. However, we will not send you communications about products or services that are subsidized by a third party without your authorization.

Individuals Involved in your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as a family member or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

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

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving these communications. Excluding the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

Other Uses. Other uses and disclosures of Health Information not listed in this notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of others. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates who perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services. All of our business associates are obliged to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health **Information to organizations that handle organ procurement or other entities engaged in** procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and, transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release Health Information as required by military command authorities. We may also release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for Workers' Compensation or similar programs that provide benefits for work-related injuries or illness.

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

Health Inspections, Audits and Licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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

Law Enforcement. We may release Health Information, if asked by a law enforcement official, if the information is: 1) in response to a court order, warrant, subpoena, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness or missing person; 3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's

authorization; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct occurring on our premises; and, 6) In an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

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

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

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be 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.

YOUR RIGHTS:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must submit your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must submit your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we make of Health Information we use or disclose for treatment, payment, or health care.

Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, investigations,
operations or for which you provided written authorization. To request an accounting of disclosures, you must submit your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you may ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must submit your request, in writing, to our office. We are not required to agree to all requests. If we agree, we will comply with your request unless the information is necessary to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must submit your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to request a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. You may obtain a copy of this notice at our website www.arroyomedicalgroup.com or you may submit a written request to our office.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

Right to Breach Notification. You have the right to be notified if there is a breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE:

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

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.