napa valley fertility center

3250 Beard Rd Napa, CA 94558
707.259.1955

Name: _____ **Date of visit: _____/_____/_____**

Age: _____ Height: _____

New Patient History

Please note: All information is confidential and will only be used for the purpose of ensuring you the best treatment possible. Please answer all areas.

Why have you come to the office today?

Who referred you to our practice? **Self** **Friend** **Physician (List name) _____**

Who is your usual Ob/Gyn? _____ Location: _____

Past Medical History (✓ if you have or have ever had)

	✓		✓		✓
Anemia/blood disease		Gall bladder disease		Prior Pulmonary Embolus (PE)	
Arthritis		Headaches/migraine		Prior blood clots (DVTs)	
Asthma		Heart disease/valve problems		Reflux/Hiatal Hernia	
Bladder problem / infections		High blood pressure		Skin disease	
Blood transfusion		Interstitial Cystitis		Stomach Ulcer	
Bowel disorder		Kidney disease		Thyroid disease	
Cancer		Leukemia		Tuberculosis	
Diabetes		Liver Disease/Hepatitis		Varicose veins/phlebitis	
Endometriosis		Lung disease		Weight loss/gain ≥ 10 lbs	
Epilepsy/Neurologic disease		PCOS (Polycystic Ovarian Syndrome)			

Other medical problems(list):_____
Please expand on any problems you identified above:_____
_____

Surgeries/Operations (any procedure, including D&C's)

Type/Reason	Date	Location	Physician

Other Illnesses/ Hospitalizations

Type/Reason	Year

Current Medications

(Include any hormones, vitamins, herbs, over the counter and nonprescription medications)

	Dose

Allergies/Reactions

(list any drug or food allergy)

Please specify what happens to you:

Gynecologic History

First day of last menstrual period: / /

Do you have regular monthly periods? Yes No
Do you feel period coming before it starts? Yes No
Which of the following do you experience before a period:
☐Breast tenderness ☐ Mood changes ☐Special food cravings

Usual number of days from start of one period to start of the next:

Any recent changes? Yes No Pain? Yes No
Describe:

Number of days of bleeding:

Age periods began:

Do you have problems with pelvic pain? Yes No
When?:
Do you have pain with defecation? Yes No

Are you sexually active? Yes No

Do you have pain with intercourse? Yes No

Sexual partner(s) is/are: Men Women Both

Have you ever had an abnormal Pap test? Yes No

Have you ever had a procedure on your cervix due to an abnormal pap test? (LEEP / Cryo / Cone) Yes No Year:

When was your last Pap test?
What was the Pap result? Normal Abnormal

Have you ever had a mammogram? Yes No
Year of last: _____ Result: Normal Abnormal

Present method of birth control: (circle) None

Pills-Patch-Ring Depo Provera IUD
Diaphragm Rhythm Method Male Condom
Withdrawl Implanon

Female Sterilization (Tubal Ligation) Male Sterilization (Vasectomy)

Have you ever had any of the following infections? (circle)

Gonorrhea Chlamydia Herpes None
HPV HIV PID

Number of times: _____ Year(s): _____

Weight at age 20: _____ Current Weight: _____

Have you ever used Birth Control Pills? Yes No

Age when started birth control: ____ Age when last stopped: ____

Hirsutism (excessive hair growth) & Acne

Do you feel that you have problems with excessive hair growth? Yes No

If yes, circle all areas of concern:
Face Chest/Breasts Back Stomach Arms Legs Thighs

Age that hair growth became noticeably worse? _____ Does this continue to worsen? Yes No

Prior Treatments: Waxing / Shaving / Plucking / Creams / Laser / Spironolactone (Aldactone)
Treated how often? _____

Do you have problems with excessive acne? Yes No At what age did acne problems begin?

Does this continue to worsen? Yes No

Current acne treatment:

Obstetrical History

	Number
Total Number of Pregnancies	
Term Births (>37 wks)	
Premature (20-37 wks)	
Miscarriages (<20 wks)	
Ectopic (Tubal) Pregnancies	
Elective Abortions	
Living Children	

Immunizations

Type	Date		Date
Have you ever had Chicken Pox?	Yes / No	TB test	
Chicken Pox vaccine		Flu vaccine	
Hepatitis A vaccine		Pneumonia vaccine	
Hepatitis B vaccine		Other:	
Rubella/MMR vaccine			
HPV vaccine (Gardasil)			
Tetanus-Diptheria-Pertussis			

Obstetrical History: Please list all pregnancies in order

	Month /year	Outcome (Yes/No)				Delivery: Vag / C-section	Complications	Length of time To conceive	Required fertility Treatment?	Current partner?
		Live born	Miscarriage	Abortion	Ectopic					
1st										
2nd										
3rd										
4th										
5th										
6th										
7th										

Social History:

Occupation:		Diet Restrictions?
Status: Married / Single	Partner / No Partner	
Length of time with current partner (years): _____		
Routine Exercise? Yes No Hours per time: _____ Times/week: _____ Type: _____		No. of meals/day: Skip meals?
Routine exposures to chemicals? Yes No		

Currently Use:

Tobacco: Yes No	Packs/day: ____ Years: ____
Have you ever smoked >100 cigarettes? Yes No	
Alcohol: Yes No	Drinks/week: _____
Caffeine: Yes No (coffee, soda, tea)	Drinks/day:
Other drugs: Yes No (Including marijuana)	Type(s):

Family History (Parents, Grandparents, Siblings, Aunts/Uncles)

Illness	✓	List affected relative(s) and age at onset
Alcohol or drug addiction		
Birth defects / Mental retardation		What was cause?_____
Bleeding disorders		
Blood clots in lungs or legs		
Breast cancer		
Cancer- Colon		
Cancer- Ovary		
Cancer- Uterus		
Diabetes		
Endometriosis		
Heart disease		
Hepatitis		
High blood pressure		
High cholesterol		
HIV		
Infertility		
Mental illness/depression		
Movement disorders (tremor)		
Osteoporosis (weak bones)		
Sickle Cell / Thalassemia		
Stroke		
Tuberculosis		
Any other genetic diseases		
Recurrent miscarriages?		List miscarriages for both your family's side and your partner's
Early menopause <40 years old. (Premature Ovarian Failure)		Age of mother at menopause if known:
Other:		

What is your ancestry? (Check mark)				
	African-American	East Asian/Pacific Islands	Hispanic/Latin Am.	South Asian
	American Indian	Caucasian	Northern European	Middle Eastern
	Ashkenazi Jewish	Eastern European	Other_____	

Fertility History (May STOP here if not being seen for fertility reasons)

Note: In order to help us more efficiently treat you, please obtain copies of your past fertility treatments, operative reports, IVF cycle, ultrasound reports, labs, and hard copies (**films or on disk**) of any

How long have you been actively trying to conceive? ___ yrs ___ mo.	Do you use lubricants? Yes No Type: _____

Hysterosalpingogram (HSG) (Xray test of your tubes) that you have had done. It is important that we review the HSG films that were previously done. Please bring these records to your appointment with you.

Number of times of intercourse per week? _____	Do you douche? Yes No
How long have you been off any birth control? _____ yrs ____ mo.	Frequency of intercourse near ovulation: _____

Prior Fertility Evaluation/Labs/Treatment

Treating physician and location:	Was a cause of infertility found?
Have you had an HSG Yes No (x-ray study of tubes)?	When? Result? Where was this performed?
Laparoscopy? Yes No Dates: _____ Number of times: _____	When? Findings? Were they able to detect if your tubes were open? Yes No
Ovulation Testing? Yes No	Do you consistently ovulate? Checked by: **Temperature / Urine Ovulation Testing / Ultrasound / Blood**
Pelvic Ultrasound? Yes No Date: _____	Where done? Any abnormal findings?

Prior fertility treatments:	✓	**Please list dates, dosage, number of cycles:**
Clomiphene (Clomid)		
Letrozole (Femara)		
Intrauterine Insemination (IUI)		
Ovulation Induction with injectable fertility medications (Menopur, Bravelle, Repronex, Gonal-F, Follistim)		
In Vitro Fertilization (IVF)		
Frozen Embryo Transfer (FET)		

Male Partner History

Partner's Name:	Age:	Height:	Weight:
Medical problems:			
Take routine medications or supplements?	Medications or supplements:		
Past surgeries: Delayed puberty? Yes No	Family History of diseases:		
Has he had a semen analysis? Yes No When? Results?	History of hernia or testicular surgery Yes No		
	History of injury to testicles Yes No		
Has he seen a Urologist? Yes No Urologist's Name/Location:	Exposure to chemicals/radiation/toxins? Yes No		
	Routine hot tub use: Yes No		
Occupation?	Wears: Boxers / Briefs		
Previously fathered a child? Yes No	Trouble with erections? Yes No		
Age of children:	Trouble with ejaculation? Yes No		
Does he currently smoke? Yes No Amount: Packs/day: Years:	Currently or has ever used any type of steroids? Yes No Length of time since last usage:		
Use marijuana or other drugs? Yes No Last use:	Any illnesses/fevers in the past 3 months? Yes No Do you suffer from headaches or visual problems? Yes No		
Alcohol use: Yes No Drinks/week:	History of sexually transmitted diseases? Yes No		
What is your ancestry? (Check mark)	African-American	East Asian/Pacific Islands	Hispanic/Latin Am. South Asian
	American Indian	Caucasian	Northern European Middle Eastern
	Ashkenazi Jewish	Eastern European	Other _____

Carrier Screening For Genetic Diseases

The goal of our practice is to make sure that you receive optimal care and attention to improve your chances of having a healthy pregnancy, and of course, a healthy child. An important part of family planning is being informed about your testing options. One of these options is genetic carrier screening. Carrier screening can help you understand your risk of having a child with a genetic disease.

Typically carriers are healthy individuals; but when two parents are carriers of the same genetic disease they can have a child affected with the disease. Most people do not know they are carriers until they have a child born with the disease.

The Universal Genetic Test screens for diseases such as Cystic Fibrosis, Tay-Sachs disease, and Sickle Cell disease. Some genetic diseases can significantly impair a child's normal development. For some of these conditions, early treatment can improve pregnancy outcomes. Your doctor can provide you with the full list of tested diseases.

If both you and your partner are carriers for the same disease, your child has a 1 in 4 (25%) chance of having that disease. If you are found to have a high reproductive risk, you have options. You may decide to have pre-implantation genetic diagnosis, a pre-pregnancy process that significantly reduces the risk that a child will inherit the genetic disease, or undergo testing during your pregnancy to make informed reproductive decisions. Some individuals consider adoption or opt to not have children. Even if you would not choose any of these options, you can use the information to prepare for the birth of a child with a genetic disorder. You will have the opportunity to speak with your physician or a genetic counselor about the medical options available to you.

Like any carrier screening test, some carriers will not be detected, so this test can reduce, but does not eliminate, the chance for a genetic disease.

The Universal Genetic Test is covered by most insurance policies. The test results will be sent to your doctor in about two weeks and you will be notified shortly thereafter.

Please take 3 minutes of your time to watch an online video and learn more:
https://www.counsyl.com/howto/intro/

Please sign this form acknowledging that you and your partner will be screened.

- ☐ My partner and I are both interested in the Universal Genetic Test.
- ☐ I am interested in the Universal Genetic Test.
- ☐ I am declining genetic carrier screening.

Patient Name	_____
Patient Date of Birth	_____
Patient Signature	_____
Today's Date	_____
Partner Name [if applicable]	
Partner Signature [if applicable]	_____

Napa Valley Fertility Center
3250 Beard Rd Napa, CA 94558
707.259.1955

Patient Name: _____ Date: ____/____/____

Address: _____
Street &/or Apt # City State Zip
Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Other: (_____)_____-_____

Email: _____ *Any restrictions for contacting you? ( ) No ( ) Yes
If yes explain restrictions for contacting: _____
Driver's License #:_____ State:_____

Birthdate: _____/_____/_____ Age: _____ Sex: ( ) Female ( ) Male SS#: _____-_____-_____

Marital Status: ( ) Single ( ) Married to: _____ ( )Other: _____

Allergies: Foods:_____ Drugs:_____

Patient's Employer: _____ Occupation: _____

Work Phone:(_____)_____-_____ Ext._____ *Is it okay to call you at work? ( )Yes ( )No

Address:_____
Street &/or Apt # City State Zip
Emergency Contact:
(Not in your household) _____ Relationship: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Other: (_____) _____-_____

Address:_____
Street &/or Apt # City State Zip
Primary Care Physician_____ **Phone:** (_____) _____-_____

Primary Health Insurance Company_____

Insurance Claims Mailing Address_____
Street &/or Apt # City State Zip
Policy #:_____ Group #:_____ Ins. Phone: (_____) _____-_____

Referral Required? ( ) No ( ) Yes *Do you have a Co-pay? ( ) No ( ) Yes, $_____

Insured: Name:_____ DOB:_____/_____/_____ Employer: _____

Secondary Health Insurance Company_____

Insurance Claims Mailing Address_____
Street &/or Apt # City State Zip
Policy #:_____ Group #:_____ Ins. Phone: (_____) _____-_____

Referral Required? ( ) No ( ) Yes *Do you have a Co-pay? ( ) No ( ) Yes, $_____

Insured: Name:_____ DOB:_____/_____/_____ Employer: _____

I understand that office visit charges are payable on the day of service is rendered. I authorize Napa Valley Fertility Center to bill my insurance company regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Signature: _____ Date: _____/_____/_____

Patient Financial Responsibility Statement

Thank you for choosing Napa Valley Fertility Center for your healthcare needs. Our staff is committed to providing you with extraordinary healthcare. This policy statement and release has been designed to inform you of our policies and answer your questions regarding payment of services. We encourage you to discuss it with us and to ask questions.

* You must pay any co-payment at the time of service
*__If you have an insurance plan with an unmet deductible at the time of your office visit, you will be expected to provide an estimated payment or furnish a credit card authorization prior to services being rendered; there are no exceptions to this.__
* The remainder of your bill will be sent to your health plan for direct payment to our office.
* If you are not insured, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered. **One exception to this: for IVF treatment, payment must be received in full prior to the prescribing of your medication**.
* In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. **You will remain responsible for required copayments, applicable deductible amounts and any services that are not covered by your insurance plan**.
* If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
* Your health plan may refuse payment of a claim for such reasons as:
    1) This is a pre-existing illness that is not covered by your plan
    2) You have not met your full calendar year deductible
    3) The type of medical service required is not covered by your plan
    4) The health plan was not in effect at the time of service
    5) You have other insurance which must be filed first

*** We will bill your insurance up to two times. If payment is not made within 60 days of the second billing, you will be expected to make cash payment in full for any services that have been rendered and have not been paid by insurance.**

*__All bills from our office will be submitted to you electronically via your email (please let us know if you prefer to receive paper bills)__

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier.

_____ _____ _____

Signature Printed Name Date

NOTICE OF PRIVACY PRACTICES

Peter S. Uzelac, MD, Inc, A Professional Corporation

Privacy Officer: Jaimie Vigil 415 925-9409

Effective Date: 9-1-13

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, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured 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.

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

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 that 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, or following your death.

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 for payment. 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 and their subcontractors 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.

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.]

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 had 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. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

22. 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.

23. 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 Officer 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 any other 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 e-mail.

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.

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 of 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.

Acknowledgement of Receipt of Notice

Peter S. Uzelac, MD, Inc, A Professional Corporation

Privacy Officer: Jaimie Vigil 415 925-9409

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: _____

***For Office Use Only*:**

- ❑ Signed form received by: _____
- ❑ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____