Patient Information Letter

Welcome to Rancho Family Medical Group. We are happy to have you as a patient. We care for those of all ages, from newborns to geriatrics. We are Southwest Riverside's largest primary care medical group. Originally established in Fallbrook, California in 1942, we now have offices not only in Fallbrook, but Temecula, Murrieta, Menifee, Sun City and Hemet.

SERVICES PROVIDED- We provide comprehensive services and procedures including, but not limited to: physical exams, wellness visits, pap smears, joint injections, skin exams/biopsies, skin cancer excision, liquid nitrogen therapy, sigmoidoscopies, treadmill testing, EKG testing, ear lavage and much more. Additionally, we provide management of chronic conditions such as diabetes, high blood pressure, thyroid imbalances, dementia, cholesterol, anxiety, depression, insomnia, and acne—among other conditions.

CO-PAY/DEDUCTIBLE: A co-pay is a portion of your visit which your insurance company requires you pay. This amount is not determined by Rancho Family Medical Group, but by your insurance company. Co-pays are paid at time of service; we accept cash, debit cards, credit cards & checks.

APPOINTMENTS: We recommend you schedule your follow up appointment before you leave the office. Otherwise, you can schedule by logging into the patient portal, online through our website, or by calling our office at 951-676-4193.

How often should you be seen?
Physicals – every 1 to 5 years depending on age.
Diabetic Visits – every 3 to 6 months
Heart Disease -every 3 to 6 months
Blood Pressure Visit- every 3 to 6 months
Thyroid- every 6 to 12 months
Controlled Substances every 3 months (Narcotics, Benzodiazepines, ADHD Medications)

If you are unable to make your appointment, please call our office 24 hours prior to your appointment, in order to avoid a missed appointment fee of $20. Additionally, you may also CANCEL an appointment by signing into the patient portal. For cancelations of SAME DAY appointments, a fee may be charged when two hours' notice is not given. We reserve the right to discharge patients who have 3 or more NO SHOWS (i.e. appointment not cancelled within 24 hours).

AFTER HOURS CARE: To keep you from long hours of waiting in the emergency room or urgent care, our physicians here at Rancho Family Medical Group are on-call 24 hours a day, to meet the urgent needs of your family. If you have an urgent need for medical attention after normal business hours (that can't wait until the morning), please call the office at (951) 676-4193. The answering service can page the on-call Rancho Family Medical Group provider for you. In the case of a life-threatening emergency, call 911.

HOSPITALS: Several providers within our group have hospital privileges at Loma Linda Medical Center Murrieta, Temecula Valley Hospital, Rancho Springs Medical Center and Inland Valley Hospital. If a patient is admitted, Rancho Family providers may see you there.

CONTROLLED SUBSTANCES: We reserve the right to NOT prescribe narcotics, benzodiazepines and other controlled substances, if it is NOT appropriate. Individuals on controlled medications are to sign a Controlled Substance Agreement (CSA). Failure to abide by the terms of the agreement between you and the "Provider" may result in being terminated or "fired" from our practice. Patients on controlled medications will be required to complete random Urine Drug Testing (UDT). The cost of UDT is the responsibility of patient's insurance and/or the patient. RFMG will not be held liable for the costs.

SPECIALISTS: As a result of our long-standing place in the community, Rancho Family has cultivated relationships with the best specialists in the area, who provide quality care to our patients.

REFILLS: If you are due for a refill please 1: contact your pharmacy 72 business hours prior to needing the refill and ask them to send us a request, 2: Login to your patient portal account and send a refill request to your healthcare provider, or 3: Call our office at 951-676-4193.

LAB TESTS AND RADIOLOGY: Insurance coverage for lab tests and radiology varies by insurance company and insurance plan. You may contact your insurance and the testing facility prior to completing lab tests or imaging ordered by your provider. The lab or imaging center will bill you for any charges not covered by your insurance. RFMG is not responsible for labs or imaging costs not covered by your insurance**.**

WHAT IS A PHYSICAL? Please be aware that if you are being seen for a health maintenance/preventive exam (aka physical exam), other acute and/or chronic problems may be assessed (such as your high blood pressure, diabetes, thyroid, etc.) and treated. Therefore, you may be charged a separate co-pay for that office visit along with your co-pay—if any—for your physical. Physicals exams are done for the purpose of ensuring preventive measures are current (skin evaluation, cancer screenings, mammogram order, vaccines, colonoscopy, etc.), not to discuss chronic or new medical problems. Discussing these at the "physical" saves you an extra office visit, but please keep in mind that upon documentation at the visit, it will generate an office visit code.

CAIR: In order to serve you best and avoid duplicate medications and vaccinations, we automatically rely on medication history from pharmacy benefit managers. Additionally, we gather immunization information from the California Immunization Registry. To be excluded from CAIR, please visit www.cairweb.org or let us know.

INJURIES: If you are being seen for an injury (i.e., fall at a store, auto accident), please inform your provider or the LVN/medical assistant. There may be a third-party information form that must be completed and signed before you leave. Sorry, we do NOT treat work related injuries.

CASH SERVICES: Some services are not covered by insurance, including—but not limited to—skin tags, cryo-therapy, botox, hair restoration, or plasma rich platelet therapy. You will be asked to pay for this procedure before you leave the office, as these are considered non-covered benefits by most insurances.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LEGAL LAST NAME	LEGAL FIRST	MI	MARITAL STATUS ■ MARRIED ■ SINGLE ■ WIDOWED ■ DIVORCED	DATE OF BIRTH	AGE	SEX

ADDRESS	APT #	CITY	STATE	ZIP	HOME PHONE NO.	SOCIAL SECURITY NO.

E-MAIL ADDRESS	CELL PHONE NO.

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	OTHER NAMES USED

* ETHNIC ORIGIN ■ AFRICAN –AMERICAN ■ ASIAN ■ CAUCASIAN ■ HISPANIC ■ NATIVE AMERICAN ■ OTHER _____

* COUNTRY OF BIRTH

* PRIMARY LANGUAGE

PERSON RESPONSIBLE FOR PATIENT'S EXPENSE

NAME LAST	FIRST	MI

ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP

RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	PHONE NO.

EMPLOYER

NAME

ADDRESS

CITY	STATE	ZIP

PHONE NO.	OCCUPATION

SPOUSE OF PERSON RESPONSIBLE

NAME LAST	FIRST	MI

ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP

RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	PHONE NO.

SPOUSE'S EMPLOYER

NAME

ADDRESS

PHONE NO.	OCCUPATION

LOCAL EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT

CITY	STATE	PHONE NO.

SECONDARY EMERGENCY CONTACT

NAME	RELASTIONSHIP TO PATIENT

CITY	STATE	PHONE NO.

INSURANCE INFORMATION

PRIMARY	Subscriber's Name	Subscriber's SSN	Subscriber's DOB	Subscriber's Emp.	Relationship to Pt.
SECONDARY	Subscriber's Name	Subscriber's SSN	Subscriber's DOB	Subscriber's Emp.	Relationship to Pt.

FOR OFFICE USE ONLY

Guarantor #	Patient #	Location #

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits be made directly to Rancho Family Medical Group. I understand that I am financially responsible to Rancho Family Medical Group for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.
This authorization will remain in effect until revoked in writing by the undersigned. I certify that the above is correct.

_____ _____

Date

Signature of Patient – If Minor, then signature of responsible person

RANCHO FAMILY
MEDICAL GROUP

Dear Patient,

Welcome to Rancho Family Medical Group! We intend to provide you with the best care the region has to offer. 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:

SCHEDULE VISITS WITH YOUR PROVIDER FOR ROUTINE PHYSICAL EXAMS AND OTHER RECOMMENDED HEALTH SCREENINGS

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. These recommended health screenings (mammogram, pap smears, etc.) can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

KEEP FOLLOW-UP APPOINTMENTS AND RESCHEDULE MISSED APPOINTMENTS

I understand that my doctor will want to know how my condition is progressing after I leave the office. Returning to my doctor on time, provides him or her the 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 evaluates as 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 failing to following my treatment plan may 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.

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 condition, please ask.

I acknowledge that I have received a copy of the Rancho Family Medical Group Welcome Letter.

_____ _____

Patient Signature Date

_____

Patient Name

Rancho Family Medical Group

CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care including routine procedures and other treatments by Rancho Family Medical Group professionals and their assistants, appointees, or consultants, as is necessary in their judgement.

2. I am aware the practice of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in Rancho Family Medical Group.

3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Furthermore, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

4. I understand that Rancho Family Group shall not be responsible or liable for the loss of, or damage to any personal property.

5. I authorize release to any party responsible for my care—including information from my records— in order for the group and all entities providing services to obtain payment. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name _____Date of Birth_____

Signature of Patient _____Date _____

Signature of Parent or Guardian _____Relationship_____

RANCHO FAMILY
MEDICAL GROUP

Fallbrook · Menifee · Murrieta · Sun City · Temecula

Zero Tolerance Policy

Rancho Family Medical Group aims to provide quality care to all of our patients. We understand there may be occasions that lead to frustration regarding circumstances or symptoms. While we attempt to provide quality care for each patient, we have zero tolerance for abuse and violence.

Examples of this include, but are not limited to those listed below:

- Multiple missed appointments without cancelling at least 24 hours prior
- Disrespectful behavior, cursing, or yelling
- Verbal abuse and physical abuse
- Threats
- Failing to follow provider instructions
- Giving false Information
- Abuse of controlled substances

We believe these types of actions compromise the provider-patient relationship and affect our ability to provide quality care. Any infraction of this zero-tolerance policy will lead to discharge from the practice. Should a patient be discharged from Rancho Family Medical Group, the patient will be notified in writing with a letter mailed to the address on file. Not receiving the letter does not preclude the patient from discharge.

_____ _____

Patient Signature Date

_____

Patient Name – Printed

RANCHO FAMILY
MEDICAL GROUP

Financial Responsibility Acknowledgement

We at **Rancho Family Medical Group** will make every attempt to collect professional medical fees due for your services from your insurance company for your effective dates of coverage. Regardless of your insurance status or absence of insurance coverage, you acknowledge that you are ultimately responsible for the balance on the account for any services rendered. You agree to pay all charges due (or which will become due) to **Rancho Family Medical Group** for the below Patient's care and treatment, including, but not limited to, co-payments, co-insurance, and deductibles, as required by your insurance plan. You may also be responsible for services denied by your insurer and for non-covered services.

You will be required to follow all of our registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying co-pays or other patient responsibility amounts prior to or at each visit. You are responsible for providing all current and updated insurance card(s) or other insurance verification prior to your appointment

As a courtesy to you, **Rancho Family Medical Group** will submit a medical claim on your behalf to the insurance company specified during registration. Payment made at the time of your visit is a deposit towards the balance owed after the insurance has been billed and the payment responsibility amount calculated. You will receive a statement from **Rancho Family Medical Group** for any remaining balances due after your payment has been applied. If you have a question regarding your statement, you must contact the Billing department at the telephone number on the statement.

Should you fail to make any payment for which you are responsible in a timely manner, you will be responsible for all costs of collecting the money owed. This may include court costs, collection agency fees, and attorneys' fees to the extent allowed by law. Failure to pay when due may subject you to late payment charges and can adversely affect your credit report.

You further agree that a photocopy of this Patient Financial Responsibility Acknowledgement shall be as valid as the original. You may request a copy of your signed Acknowledgement from the office staff.

I certify that I have read this statement and my signature, whether by original, facsimile or electronic signature indicates agreement to the terms and conditions contained herein.

Print _____ Sign _____ _____
Patient/Responsibility Party/Guardian Date

Print _____ Sign _____ _____
Patient/Responsibility Party/Guardian Date

RANCHO FAMILY
MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 01-01-2019

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.

Rancho Family Medical Group (the Practice) participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants within the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. Your health information is integrated into UCSD's electronic health recordkeeping system. UCSD also has its own Notice of Privacy Practices that can be accessed at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.

The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals.

A. How this Medical Practice May Use or Disclose Health Information

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

1.Treatment. We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share 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, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them when they are sick or injured, or following the patient's death.

2.Payment. We use and disclose PHI to obtain payment for the services we provide. For example, we give health plans the information they require for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

3.Health Care Operations. We may use and disclose PHI 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 health plans 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 PHI 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 this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of health care information from further disclosing it except as specifically required or permitted by law.

a. We may also share PHI with other health care providers, health care clearinghouses, or health plans that have a relationship with our patients 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.

b. We may also share PHI 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 that collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. We may use and disclose medical information to contact and remind our patients about appointments. If the patient is not home, we may leave this information on the patient's answering machine or in a message left with the person answering the phone.

5. Check-in Process. We may use and disclose medical information about our patients by calling out their names when we are ready to see them.

6. Notification and Communication with Family. We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about

their location or general condition in the event of their 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 our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact our patients to encourage them to purchase or use products or services related to their 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 them. We may similarly describe products or services provided by this practice and tell our patients which health plans we participate in. We may receive financial compensation to talk with our patients face-to-face, to provide them with small promotional gifts, or to cover our cost of reminding them to take and refill medication or otherwise communicate about a drug or biologic that is currently prescribed for the patient, but only if the patient either:
(1) has a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise the patient about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) the patient is a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while the patient has 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) the patient's right to opt-out of future remunerated communications by calling the communicator's toil-free number. We will not otherwise use or disclose PHI for marketing purposes or accept any payment for other marketing communications without the patient's prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity our patients authorize, and we will stop any future marketing activity to the extent the patient revokes that authorization.

8. Sale of Health Information. We will not sell our patients' health information without their prior written authorization. The authorization will disclose that we will receive compensation for PHI if the patient authorizes us to sell it, and we will stop any future sales of information to the extent that the patient revokes that authorization.

9. Required by Law. As required by law, we will use and disclose our patients' 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 our patients' 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 our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient 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 our patients' 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 our patients' 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 our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose out patients' 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 our patients' health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose our patients' 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 our patients' 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 the patient has agreed to the disclosure on behalf of themselves or their dependent.

18. Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in their lawful custody.

19. Workers' Compensation. We may disclose our patients' health information as necessary to comply with workers' compensation laws. For example, to the extent our patients' care is covered by workers' compensation, we will make periodic reports to their employer about their conditions. 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, our patients' health information/record will become the property of the new owner, although our patients will maintain the right to request that copies of their 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 our patients as required by law. If they 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. Other disclosures specified in our Notice of Privacy Practices. We may disclose our patients' health information as otherwise described in our Notice of Privacy Practices.

23. Psychotherapy Notes. We will not use or disclose our patients' psychotherapy notes without their prior written authorization except for the following: (1) treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if the patient sues us or brings some other legal proceeding, (4) if the law requires us to disclose the information to the patient or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning the patient's psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner following the patient's death. To the extent the patient revokes an authorization to use or disclose their psychotherapy notes, we will stop using or disclosing these notes.

24. Research. We may disclose our patients' health information to researchers conducting research with respect to which their written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

25. Fundraising. We may use or disclose our patients' demographic information, the dates that they received treatment, the department of service, their treating physician, outcome information and health insurance status in order to contact them for our fundraising activities. If they do not want to receive these materials, the patient can notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, the patient should notify the Privacy Officer if they decide they want to start receiving these solicitations again.

B. When this Medical Practice May Not Use or Disclose 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 individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

C. Our Patients' Health Information Rights

1. Right to Request Special Privacy Protections. Our patients have the right to request restrictions on certain uses and disclosures of their health information by a written request specifying what information they want to limit, and what limitations on our use or disclosure of that information they wish to have imposed. If our patients tell us not to disclose information to their commercial health plan concerning health care items or services for which they paid for in full out-of -pocket, we will abide by their 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 our patients of our decision.

2. Right to Request Confidential Communications. Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send

information to a particular email account or to their work address. We will comply with all reasonable requests submitted in writing which specify how or where our patients wish to receive these communications.

3. Right to Inspect and Copy. Our patients have the right to inspect their health information, with limited exceptions. To access their medical information, our patients must submit a written request detailing what information they want access to, whether they want to inspect it or get a copy of it, and if they want a copy, their preferred form and format. We will provide copies in the requested form and format if it is readily producible, or we will provide our patients with an alternative format they find acceptable, or if we can't agree and we maintain the record in an electronic format, their choice of a readable electronic or hardcopy format. We will also send a copy to any other person our patients 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 our patients' request under limited circumstances. If we deny a request to access a child's records or the records of an incapacitated adult because we believe allowing access would be reasonably likely to cause substantial harm to the patient, the guardian or legal representative will have a right to appeal our decision. If we deny a patient's request to access their psychotherapy notes, our patients will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete. Our patients must make a request to amend in writing, and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information, and will provide them with information about this medical practice's denial and how they can disagree with the denial. We may deny their 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 they 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 a request, our patients may submit a written statement of their disagreement with that decision, and we may, in turn, prepare a written rebuttal. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning anything in the record they 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. Our patients have a right to receive an accounting of disclosures of their health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to them or pursuant to their 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.Right to Paper Copy of Notice of Privacy Practices. Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email.

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.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles our patients' health information should be directed to our Privacy Officer.

If our patients are not satisfied with the manner in which this office handles a complaint, they may submit a formal complaint to:

Rancho Family Medial Group/Privacy Officer
28780 Single Oak Drive Suite 160 Temecula, CA 92590
or by calling (951) 676-4193.

I hereby acknowledge that I have been presented with a copy of Rancho Family Medical Group's Notice of Privacy Practices and Patient Information Letter.

_____ _____

Patient Signature Date

_____

Patient Name – Printed

RANCHO FAMILY
MEDICAL GROUP

COMMUNICATION CONSENT AGREEMENT

I understand that under the federal law Health Insurance Portability & Accountability Act of 1997, this medical office may not release any medical information to any individual without my expressed written permission. I therefore, give permission to Rancho Family Medical Group to release pertinent information on my behalf, in the following ways and to the following person(s), if any:

①

Consent to Leave Voice Mail Message - I understand that as part of my health care and treatment, Rancho Family Medical Group may need to reach me by phone. To provide effective care, I authorize Rancho Family Medical Group Providers and staff to **leave detailed messages regarding labs results, x-ray results, refills, prescriptions, treatment, etc. using a personal telephone number I have provided to be listed in my medical chart. This will allow me to hear of my results as quick as possible.**

***** If I change my contact telephone number, I will notify Rancho Family Medical Group as soon as possible using the patient portal, telephone, or in person. *****

I agree that If I am not contacted about my test results, I will call Rancho Family Medical Group and inquire about my results. No news DOES NOT mean good news, it may simply mean my provider did not receive the results. Ultimately, I, the patient, am responsible for following up on test results, referrals and prescribed medications.

②

I authorize Rancho Family Medical Group to Provide Information to:

☐ **Myself** **OR** ☐ **Myself and the person listed below**

Name: _____Relation to patient: _____
Address: _____ City _____State_____Zip Code_____
Phone (home) _____(mobile)_____ Birthdate: _____
Driver's License # (if known):

③

Patient Name: (print your complete name) _____

Rancho Family Medical Group will consider anyone given consent for communication able to receive medical information about the patient until notified otherwise by the patient.

Signature: _____Date: _____

Patient ID(circle) Driver's License / State Identification / Passport / Other: _____
(Identification must be non-expired)
Authorization Received By: _____Date: _____

If applicable, revoke consent for (Name): _____
(This will **VOID** your prior consent form signed with Rancho Family Medical Group)
Date Effective: Immediately

I agree to sections 1, 2 and 3 as listed above.

Patient Signature: _____ Date: _____