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 in Fallbrook, Temecula (3), Murrieta, Menifee, Sun City and Hemet (Opening Soon).

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

ONLINE PORTAL: The online portal gives patients secure access to portions of their electronic charts, as required by Medicare and most insurance companies. All you need is an email address to sign up. Once invited to join, you can access by visiting www.RanchoFamilyMed.com. Ask our staff to help sign up. Lab results, X-ray results and more may be sent directly to your patient portal once reviewed.

PATIENT FEEDBACK: We have thousands of patients visit each month and the majority are extremely satisfied; which explains our growth from a single office in 2010 to 8 offices in 2017. However, we understand that there are times when a patient may not be satisfied with their care. We value all feedback and take all concerns seriously. If you have comments about your visit, please send an email to feedback@ranchomed.com. We encourage those who are satisfied with their care to leave feedback online on sites like Healthgrades.com, Yelp.com, Facebook.com or FiveStarDoctors.com. For your protection, we recommend against posting information about your health conditions.

CO-PAY/DEDUCTIBLE: A co-pay is the portion of your visit that your insurance company requires you pay. This amount is not determined by Rancho Family Medical Group, but by your insurance company. Paid at time of service, we accept cash, debit cards, credit cards & checks. There is a $20 Non-Sufficient Fund charge for all checks returned by your bank.

APPOINTMENTS: To Schedule - We recommend you schedule your follow up appointment before you leave the office. Otherwise, you can schedule by logging into the patient portal 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)

In order to avoid a missed appointment fee of $20, please call our office 24 hours prior to your appointment if you are unable to keep your appointment. Additionally, you may also CANCEL by signing into the patient portal. A fee may be charged for not canceling a SAME DAY appointment two hours in advance. We reserve the right to discharge patients who have 3 or more NO SHOWS (i.e. appointment not cancelled within 24 hours) in a 12 month period.

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 healthcare provider for you. In the case of a life-threatening emergency, call 911.

URGENT CARE (Temecula Parkway office)- Our various providers rotate as the urgent care provider from 9:00 am to 7:30 pm on weekdays, Saturdays 9:00am to 5:00 pm and Sundays 10:00am to 4:00pm. (hours subject to change). If you have an urgent situation that requires immediate attention, please call our office at (951) 676-4193 for an appointment. Hours of urgent care may vary so please check prior. In the case of a life-
threatening emergency, call 911.

**Menifee URGENT CARE** - The Menifee Office is open Saturdays from 8 AM to 12 PM (hours for urgent care subject to change). In the case of a life-threatening emergency, call 911.

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

**PRESCRIPTIONS:** There is a $10 *over-the-phone, New Prescription charge*, if a prescription is sent to your pharmacy due to an electronic visit/portal request for treatment of urine infections, influenza, sinus infections, etc. This is a service offered to our patients as a convenience and is done in lieu of an office visit and possible co-pay, if applicable. The treatment fee will be added onto your account.

**CONTROLLED SUBSTANCES:** We reserve the right to NOT prescribe narcotics, benzodiazepines and other controlled substances if it is NOT appropriate. Those 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 also be required to do random Urine Drug Testing (UDT). The cost of Urine Drug Screening is the responsibility of patient’s insurance and/or the patient. RFMG will not be held liable for the costs.

**SPECIALISTS:** Since our group has been around for an extended time, we have cultivated relationships with the best specialists in the area, who provide quality care to our patients.

**REFILLS:** If you are due for a refill, 1: Please 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 testing facility before you complete 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 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 high blood pressure, diabetes, thyroid, etc.) and treated, and therefore you may be charged a separate co-pay for that office visit along with your co-pay—if any—for your physical, if your plan allows. **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 of the visit, it will generate an office visit code.**

**EXTRA FEES:** Note: A fee will be charged for forms (jury duty excuses, disability, letters, etc.) completed by the provider and/or staff. Prices vary.

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

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

**CASH SERVICES:** Some services are not covered by insurance, including but not limited to skin tags, cryotherapy, botox, hair restoration, or plasma rich platelet therapy. You will be asked to pay for this procedure before you leave the office as this is usually considered a non-covered benefit by most insurances.
# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>PATIENT’S LEGAL LAST NAME</th>
<th>LEGAL FIRST</th>
<th>MI</th>
<th>MARITAL STATUS</th>
<th>DATE OF BIRTH</th>
<th>AGE</th>
<th>SEX</th>
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<th>ADDRESS</th>
<th>APT #</th>
<th>CITY</th>
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<th>E-MAIL ADDRESS</th>
<th>CELL PHONE NO.</th>
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<th>MAILING ADDRESS (IF DIFFERENT FROM ABOVE)</th>
<th>OTHER NAMES USED</th>
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<th>* ETHNIC ORIGIN</th>
<th>* COUNTRY OF BIRTH</th>
<th>* PRIMARY LANGUAGE</th>
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## PERSON RESPONSIBLE FOR PATIENT’S EXPENSE

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<tr>
<th>NAME LAST</th>
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<th>NAME</th>
<th>ADDRESS</th>
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<tr>
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<th>SOCIAL SECURITY NO.</th>
<th>PHONE NO.</th>
<th>OCCUPATION</th>
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## SPOUSE OF PERSON RESPONSIBLE

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<tr>
<th>NAME LAST</th>
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<th>NAME</th>
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## LOCAL EMERGENCY CONTACT

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<tr>
<th>NAME</th>
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## SECONDARY EMERGENCY CONTACT

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## INSURANCE INFORMATION

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<th>Subscriber’s Emp.</th>
<th>Relationship to Pt.</th>
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<th>SECONDARY</th>
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<th>Subscriber’s DOB</th>
<th>Subscriber’s Emp.</th>
<th>Relationship to Pt.</th>
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## FOR OFFICE USE ONLY

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<tr>
<th>Guarantor #</th>
<th>Patient #</th>
<th>Location #</th>
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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
Dear Patient,

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

**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. I understand that I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for 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 progresses after I leave the office. Returning to my doctor on time gives 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 within the time specified, I will call the office for my test results.

**INFORM MY DOCTOR IF I DECIDE NOT TO FOLLOW HIS OR HER RECOMMENDED TREATMENT PLAN**

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

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.

__________________________________________  ______________________
Patient Signature                              Date

__________________________________________
Patient Name – Printed
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. Further, 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 the release to any party responsible for my care, such information from my records as is required 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 ________
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
- Not following 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
The following disclosure is furnished in compliance with the Federal Truth-in-Lending Act.

Rancho Family Medical Group shall charge a FINANCE CHARGE on any part of the “previous balance” as shown on the periodic statement form the group, which remains unpaid in excess of the 90 days after the first billing of the “previous balance” at the periodic rate of 1.25 % per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement. The ANNUAL PERCENTAGE RATE is 15% per annum.

There shall be in all cases a minimum FINANCE CHARGE of $.50 per month. Said minimum charge may result in ANNUAL PERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any “previous balance” as shown on the periodic statement, which is paid 90 days from the first billing of the “previous balance” or on any current charges listed on the periodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle.

All payments received shall be first applied to any FINANCE CHARGE assessed to the account, and then to the portion of the “previous balance” which is more than 90 days unpaid and then that portion of the “previous balance” which is less than 91 days unpaid and then to the current charges listed on the periodic statement, and finally to credit.

You may pay your entire balance at any time

Any credit balances of $5.00 or less will be automatically applied to your next visit.

**You are responsible for payment on your account regardless of insurance.** The Rancho Family Medical Group cannot accept the responsibility for collecting your insurance claims or negotiating a settlement on a disputed claim. Notwithstanding insurance benefits that may have accrued, the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by insurance benefits.

Rancho Family Medical Group will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Rancho Family Medical Group reserves the right to obtain assignment of benefit for payment of balances accrued at the group.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Patient Signature_______________________________ Date ______________
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: 01-01-2017

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.

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 toll-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 our patients' health information to a law enforcement official for purposes such as identifying or 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 Medical 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

__________________________________________

Patient Name – Printed

____________________

Date