Cardiology Questionnaire

Name ____ Phone Number ______________________ Date of Birth_____________

Referring Physician ____ Other Physician (if any) ___________________________________

What is the main reason you are seeing a heart doctor today? ____

Current Medications

(Including aspirin, vitamins, antacids, eye drops, laxatives, herbal medicines, etc.)

BRING ALL MEDICATIONS IN THEIR ORIGINAL CONTAINERS TO EVERY APPOINTMENT!

	Drug Name	Strength	# of tablets each time	# of times per day
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Do you have ALLERGIES or REACTIONS to any medication, iodine, seafood, or x-ray contrast dye? Please describe.

	Drug name	Reaction
1.		
2.		
3.		

PAST MEDICAL HISTORY: Have you ever had any of the following?

☐ Anemia
☐ Anesthesia Complications
☐ Asthma
☐ Atrial Fibrillation
☐ Cerebrovascular Accident (Stroke)
☐ Cerebrovascular Disease
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Heart Disease
☐ Chronic Renal Failure
☐ Deep Vein Thrombosis

☐ Diabetes- **requires insulin or does not require insulin** (please circle)
☐ Dialysis
☐ Endocarditic (infection around the heart)
☐ Gastrointestinal Bleeding
☐ GERD
☐ Hepatitis A B C (please circle)
☐ HIV
☐ Hyperlipidemia (high cholesterol)
☐ Hypertension (high blood pressure)

☐ Impotence
☐ Kidney Disease (nephropathy)
☐ Liver Disease
☐ MI (heart attack)
☐ Palpitations
☐ Pulmonary Embolism
☐ Peripheral Vascular Disease
☐ Stroke
☐ Syncope (dizziness, fainting)
☐ Valvular Heart Disease

Name:________________________

PAST SURGICAL HISTORY:

Have you had any previous Cardiac surgeries or procedures?

Where When

Cardiac Catheterization ____
Cardioversion ____
Coronary angioplasty or stent ____
Angioplasty on other arteries (neck, legs) ____
Coronary Bypass Surgery ____
Electrophysiology Study ____
Heart Valve or other heart surgery ____
Implanted defibrillator ____

PLEASE LIST ALL OTHER SURGERIES AND HOSPITALIZATIONS

Where When

1. ______________________ ______________________
2. ____
3. ____
4. ____

CARDIAC TESTS

Have you ever had any of the following?

Where When

Echocardiogram ____
Heart CAT scan ____
Holter monitoring ____
Stress test (treadmill) ____

FAMILY HISTORY: Has anyone in your family had the following? If yes check box and how old when event occurred.

	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Aortic Aneurysm								
Bleeding Disorder								
Bypass Surgery								
Coronary Angioplasty								
Stent								
Coronary Heart Disease								
Diabetes								
Heart Attack								
Heart Rhythm problems								
High Cholesterol								
Hypertension (high blood pressure)								
Stroke								
Sudden Cardiac Death								

CARDIAC RISK FACTORS:

Tobacco Use: Yes No
Smoke status: Current Quit Never
Type: Cigarettes Cigars Pipes
Year started _________
Packs/Day __________
Counseled to quit/cut down?
Yes No

Passive smoke exposure?
Yes No
Drug Use:
Yes No
Substance _____________
Caffeine Use: Yes No
Cups per day _____________

Exercise: Yes No
Times per week ___________
Type_____________________
Alcohol Use: Yes No
Drinks per day _______________
Counseled to quit/cut down?
Yes No

Name: ________________________________

REVIEW OF SYSTEMS: Check if you are experiencing any of the symptoms listed below

General

- ☐ Fever
- ☐ Fatigue/weakness
- ☐ Weight loss
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia
- ☐ Malaise
- ☐ Sleep disorder

Eyes

- ☐ Blurring
- ☐ Double vision - Diplopia
- ☐ Irritation
- ☐ Discharge
- ☐ Vision loss

ENT

- ☐ Tinnitus
- ☐ Decreased hearing
- ☐ Nosebleeds
- ☐ Hoarseness

Cardiovascular

- ☐ Chest pain at rest
- ☐ Chest pain with exercise
- ☐ Palpitations
- ☐ Peripheral edema
- ☐ PND
- ☐ Orthopnea
- ☐ Shortness of breath
- ☐ Dyspnea on exertion
- ☐ Syncope
- ☐ Claudication
- ☐ Orthostatic symptoms

Respiratory

- ☐ Cough
- ☐ Dyspnea at rest
- ☐ Hemoptysis
- ☐ Wheezing
- ☐ Pleurisy
- ☐ Shortness of breath
- ☐ History of TB
- ☐ Excessive snoring
- ☐ History of sleep apnea
- ☐ Daytime somnolence

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Abdominal pain
- ☐ Hematochezia
- ☐ Jaundice
- ☐ Gas/bloating
- ☐ Indigestion/heartburn
- ☐ Dysphagia
- ☐ Odynophagia

Genitourinary

- ☐ Incontinence
- ☐ Dysuria
- ☐ Hematuria
- ☐ Urinary frequency
- ☐ Pelvic pain
- ☐ Decreased libido
- ☐ Discharge
- ☐ Urinary hesitancy
- ☐ Nocturia
- ☐ Erectile dysfunction

Muscular skeleton

- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Arthritis
- ☐ Restless legs
- ☐ Leg pain at night
- ☐ Leg pain with exertion

Dermatology

- ☐ Rash
- ☐ Itching
- ☐ Dryness

Neurology

- ☐ Paralysis
- ☐ Parasthesias
- ☐ Seizures
- ☐ Vertigo
- ☐ Dizziness
- ☐ Frequent falls
- ☐ Frequent headaches
- ☐ Difficult walking

Psychology

- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Suicidal ideation
- ☐ Paranoia
- ☐ Confusion

Endocrine

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Polyuria
- ☐ Unusual weight change
- ☐ Excessive sweating
- ☐ Hair loss

Hematology

- ☐ Enlarged lymph nodes
  Where_______________
- ☐ Bleeding
- ☐ Abnormal bruising

Allergy

- ☐ Urticaria
- ☐ Allergic rash
- ☐ Hay fever

ADVANCED DIRECTIVES:

- ☐ None
- ☐ Health Care Proxy (Power of Attorney)
- ☐ Living Will
- ☐ Do Not Resuscitate

South Valley Multi-Specialty Medical Group

PLEASE PRINT AND Complete ALL sections below!

PATIENT'S PERSONAL INFORMATION Marital status: ☐ Single ☐ Married ☐Divorced ☐Widowed Sex: ☐ Male ☐ Female

Name: ____
Last name First name Initial

Street: ______________________________ City: ________________

State: ____________ Zip Code: ____________Date Of Birth ________________

Home Phone: (____) __________ Work Phone: (____) __________ Cell Phone: (____) __________

Referring Physician: ________________ Driver's License: (state & number) ________________

S.S. # ____________ Email: ________________ Language: __________

Employer/Occupation ________________________ Race: ______________

RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE COMPANY: ________________________________

Address: ________________________________ Phone number (____) __________

Name of insured: ________________ S.S. # ____________ Date of Birth: __________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________

ID # ________________________ Group # ________________________

Employer: ____

SECONDARY INSURANCE COMPANY: ________________________________

Address: ________________________________ Phone number (____) __________

Name of insured: ________________S.S. # ____________ Date of Birth: __________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other ________________

ID # ________________________ Group # ________________________

Employer: ____

EMERGENCY CONTACT

Name: ________________________ Relationship: ________________

Cell: (____) ________________ Other: (____)________________

Assignment of Benefits ♦ Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to SOUTH VALLEY MULT-SPECIALTY MEDICAL GROUP, and any assisting physicians, for services rendered. I understand that failure to cancel 24 hours prior to any appointment will result in a fee and that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ________________ Your Signature: ________________________________

SOUTH VALLEY MULTI-SPECIALTY MEDICAL GROUP

173 N MORRISON AVE. SUITE C
SAN JOSE, CA 95126

TINO GALLO, MD
NORMAN LOWENBRAUN, MD
408-293-1992

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMEBERS

In accordance with the Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of South Valley Multi-Specialty Medical Group, Inc. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

______ I authorize South Valley Multi-Specialty Medical Group, Inc. to verbally release any and all information concerning my medical care to the following individuals.

____ __________________________
Name Relationship to Patient

____ __________________________
Name Relationship to Patient

____ __________________________
Name Relationship to Patient

____ __________________________
Name Relationship to Patient

____ __________________________
Name Relationship to Patient

______ I authorize South Valley Multi-Specialty Medical Group, Inc. to leave messages regarding my medical care or appointments on my answering machine/voice mail.

____ __________________________
Patient Signature Date

SOUTH VALLEY MULTI-SPECIALTY MEDICAL GROUP

173 N. MORRISON AVENUE, SUITE C
SAN JOSE, CALIFORNIA 95126
(408) 293-1992

TINO GALLO, M.D.
NORMAN LOWENBRAUN, M.D.

STATEMENT OF FINANCIAL RESPONSIBLITY

* Our office will attempt to make a reminder call prior to your appointment. This is a courtesy call only. If you need to cancel or change your appointment time, it is your responsibility to contact the office at least 24 hours prior to your appointment. Failure to do so will result in a cancellation fee.

Please note that additional notice may be required for certain tests and procedures. Review the paperwork you receive when scheduling tests and other procedures for important information.

* Co-payments are due and payable at the time of service. Failure to make this payment at the appointment will result in an administrative fee.

* You are financially responsible for fees and charges for medical services provided by SVMSMG.

Although we process your insurance claims, we are not always reimbursed in a timely manner. If for any reason your insurance does not pay us within 90 days, you will be billed and held responsible for outstanding charges. You may then pursue reimbursement through your insurance company.

It is important to advise this office of any changes in your medical insurance plan or status prior to your scheduled appointment.

* An administrative fee will be charged in the event of a returned check.

I have read and understand the preceding statements and acknowledge financial responsibility.

PRINTED NAME	PATIENT/RESPONSIBLE PARTY SIGNATURE	DATE

PHARMACY INFORMATION

Patient Name: ____

Pharmacy Name: ____

Address: ____

City, State: ____

Phone #: ____

Fax #: ____

South Valley Multi-Specialty Medical
Group, Inc.

Privacy Officer: Alejandra Diaz 408-293-1992

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

☐ 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 relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

Name and Address of Patient:____

____

____

NOTICE OF PRIVACY PRACTICES

South Valley Multi-Specialty Medical
Group, Inc

Effective Date: 9/23/2013

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.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information .... p. 22

B. When This Medical Practice May Not Use or Disclose Your Health Information ....p. 25

C. Your Health Information Rights ....p. 25

1. Right to Request Special Privacy Protections
2. Right to Request Confidential Communications
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper or Electronic Copy of this Notice

D. Changes to this Notice of Privacy Practices ....p. 26

E. Complaints ....p. 27

© 2014 by PrivaPlan™ Associates, Inc. and the California Medical Association
Patent Pending. All Rights Reserved

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. [*Participants in organized health care arrangements only should add*: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. [Optional: 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. <u>Notification and Communication with Family</u>. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. <u>Marketing</u>. 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. <u>Sale of Health Information</u>. 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. <u>Required by Law</u>. 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. <u>Public Health</u>. 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. Workers' Compensation. We may disclose your health information as necessary to comply with workers' 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.]

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 healthcare 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 email.

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

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add*: 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: Alejandra Diaz 408-293-1992

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

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)

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.