DEMOGRAPHIC INFORMATION

*	*			*
Patient Last Name	First Name	M.I.	SSN	DOB
*			*	*
Address			Phone	Email/2nd Phone

*	*	*
Emergency Contact Name	Phone	Address
Emergency Contact Name	Phone	Address
Primary Physician Name	Phone	Address
Pharmacy Name	Phone	Address

Therapist Name	Phone	Address
Psychiatrist Name	Phone	Address

Patient Signature

Date

Embrasse Staff Signature

Date

COVID-19 Patient Screening Form

Patient Name	**Please Circle**
Are you over 60 years of age?	YES/ NO
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	YES/ NO
Are you experiencing shortness of breath or trouble breathing?	YES/ NO
Do you have a temperature of 100.4° F or higher?	YES/ NO
Are you experiencing a sore throat?	YES/ NO
Are you coughing?	YES/ NO
Are you experiencing repeated shaking with chills?	YES/ NO
Do you have muscle aches?	YES/ NO
Are you experiencing gastrointestinal changes?	YES/ NO
Have you noticed a loss of smell or taste?	YES/ NO
Have you had contact with a known or suspected COVID-19-positive person?	YES/ NO
In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?	YES/ NO

Initial:_____ Date:_____

If you answered YES to any of the above questions, we insist that you remain at home, consult with your primary physician, and we will gladly reschedule your appointment or make arrangements for a virtual meeting. Thank you for your cooperation.

At Embrasse, we practice hand washing, hand sanitization, social distancing, utilization of personal protective equipment, disinfection of high contact areas, and offer video conferencing for at risk patients in accordance to CDC guidelines.

HEALTH QUESTIONAIR

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

Patient Name:* _____ **Date of Birth:*** _____ **Today Date:*** _____

MEDICAL HISTORY

Please list any medication allergies or reactions: * _____

Please check to indicate if you have ever had the following conditions:

__Diabetes __Seizures __High blood pressure __Stroke __Coronary Artery Disease
__Hepatitis __Thyroid disease __Heart attack __Arrythmia __Congestive Heart Failure
__Kidney disease __Tuberculosis __Emphysema __Asthma __Coronary Artery Disease
__Depression __Sexually transmitted disease – type:_____ __Eye problems– type:_____
__Cancer –type:_____ Others:_____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization / location *Date*

_____ _____
_____ _____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

_____

When was your last physical exam? _____

Please list <u>all</u> medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

*Medication Name/Dosage:** _____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider Name:_____ What they treat you for:_____
Provider Name:_____ What they treat your for:_____

Please note dates of your most recent immunizations:

	Approximate Date		*Approximate Date*		*Approximate Date*
Tetanus	_____	Influenza	_____	Pneumonia	_____
Hepatitis B	_____	Other	_____	Other	_____

If you have had any of the following tests done, please note when the tests was done and what the results were, if known:

Test	*Date*	*Result*	*Test*	*Date*	*Result*
Cholesterol	_____	_____	Pap smear	_____	_____
Mammogram	_____	_____	Prostate	_____	_____
Colonoscopy	_____	_____	Hgb A1c	_____	_____
TB	_____	_____			

HEALTH HABITS

Do you smoke or use any tobacco products? ..... …__ Yes __No __Quit
If yes: Number of cigarettes each day? _____For how many years? _____If you use marijuana, how much? _____
Do you drink alcohol?_____ __Yes __No __Quit
If yes: How much? _____ How often? _____
Have you ever felt that you should cut down on your drinking? _____ __Yes __No
Have you regularly used other drugs?_____ __Yes __No If yes, are you still using them? __Yes __No

Check any of the diseases that run in your family and please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Child	Other (Please explain)
Alcoholism or Drug Use											
Cancer											
Cancer Type											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

PERSONAL HISTORY

Are you currently married or living with a significant other? _____ __Yes __No

Who lives with you at home?_____

Are you employed? __Yes __No If yes, what kind of work do you do? _____

If no, is this by choice? __Yes __No __Disability? Other reasons?_____

Do you exercise more than 2 times per week? __Yes __No

Do you often feel sad or depressed? __Yes __No

Do you feel there is something seriously wrong with your body? __Yes __No

Are you having money problems which limit your access to food, shelter or medical care? __Yes __No

In the last year, have there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? __Yes __No

Do you have some form of church or spiritual support? __Yes __No

SEXUAL HISTORY

Are you sexually active? __ Yes __No With:__Men __Women __Both

Do you feel you are at risk for HIV/AIDS? __Yes __No

Do you have children? __Yes __No How many children do you have? ____

Do you use any form of birth control? __Yes __No If yes, which type / brand? _____

WOMEN HISTORY

Have you ever been pregnant? __Yes __No How many times?____ How many abortions?____

How many miscarriages?____ How many children do you have living? _____

Do you have menstrual periods?__ Yes __No If no, at what age did they stop? ___If yes, are your periods regular? +

OTHER COMMMENTS

_____

PATIENT FINANCIAL AGREEMENT

The following information is provided to all patients, new and established, to inform patients of our office financial policies and patient financial responsibility requirements. Please ask one of our team members if you have any questions regarding these policies.

Embrasse is committed to serving our patients with professionalism and caring, and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your current identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash or credit cards such as Visa, Mastercard Card and Discover. Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. It is your responsibility to update us if there are changes in your insurance carrier and or coverage. Your insurance company may require you to supply certain information directly. It is your responsibility to comply with their request.

- **Co-Payments:** Your insurance company requires us to collect co-payments including co-pay, co-insurance and deductibles are due prior to surrender service.

  **** Co-pay:** Your co-pay is a fixed amount for each visit which is assessed per your insurance policy.

  **** Co-Insurance:** Your Co-Insurance is in the form of a percentage; it is estimated and calculated based upon the percentage multiply by **$200.00** for the first visit and **$150.00** per visit thereafter. For example, your co-insurance is 20%. Your initial payment for your first visit is $40 (20% multiply by $200). Please note the payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.

  **** Deductible Payments:** If your insurance requires you to meet a deductible before services are covered by your insurance company, payment must be made at the time of service. An estimated **$200.00** payment will be due at the time of service for the first visit and **$150.00** per visit thereafter. Please note the **$200.00** and **$150.00** payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.

- **Claims Submission:** As a courtesy, Embrasse will file your insurance claim for you; however, all charges, regardless of insurance coverage are the patient's responsibility. Payment from your insurance company is expected within **45 days**. If your insurance has not paid within **45 days** from the date of visit, please follow up with the insurance. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **If your insurance payments are not received by our office after 60 days, we will look to you for payment in full.**

- **Self-Pay Patients:** The payment is due at the time of service. The amount you pay for the day of scheduled office visit may not be your final payment. Other costs that may be accrued for the appointment are including, but not limited to, injections, special procedures, or additional office visit charges.

- **Laboratory Bills:** Any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact your laboratory directly for any questions regarding your lab bill.

- **Therapy Appointments**: Due to the complexity and the length of the appointment, we require an active credit card for payment on file.

- **Missed Appointments:** Please note a **$75.00** cancellation fee will apply for missed appointments or failure to cancel least 1 business day prior to your scheduled appointment date. These charges are not associated with your insurance and will be your responsibility and billed directly to you. If you missed three appointments within 12 months period, we may dis-enroll you from our office. Please help us to serve you better by keeping your regularly scheduled appointment.

- **Administrative Charges:** Any additional paperwork requests outside of your appointment will be charged based on each request. These charges are not associated with your insurance and will be your responsibility and billed directly to you. Patients who have paid an administrative fee prior to 2022 are not subject to these charges.

- **Payment Enforcement:** It is necessary to strictly enforce the policy of financial obligation. We would ask that you pay your balance within 30 days following your invoice date. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills.

- **Financial Hardship:** If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim, and payment of medical benefit is to be paid directly to Embrasse for all services rendered. ***Initials:*** _____

I have read and understand entire the above statements. I agree to comply with the financial policies of the office, and I am financially responsible for my account.

Patient or Guardian Name:*_____ ***Date of Birth:*** *_____

Patient or Guardian Signature:_____ ***Date:***_____

AUTHORIZATION FOR CREDIT CARD PAYMENT(S)

Patient's Name: *_____ Patient's Birthdate: *_____

(Circle One) VISA / MASTERCARD

Cardholder Name: *_____

Credit Card Number: *_____

Expiration Date: *_____ Security Code:*_____

Cardholder Billing Address: _____

City: _____ State: _____Zip: _____

Cardholder Phone Number: _____

Cardholder Email Address: _____

I authorize Embrasse to charge for all expenses that is not covered by patient's insurance and or patient.

Cardholder Authorized Signature: *_____

Patient or Guardian Signature: _____

Note: *Please attach the cardholder's identification.*

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

At Embrasse, we understand the importance of privacy and we are committed to maintaining the confidentiality of your personal health information. We are required by law to maintain the privacy of protected health information and provide you our Privacy Practice Notice. The Privacy Practice Notice is posted in our office where it can be viewed by staff, patients and guests.

By signing below, you acknowledge that you have received Embrasse's Notice of Privacy Practice.

I, *_____understand that it is my responsibility to read and understand Embrasse's Notice of Privacy Practice. I further understand that I should consult Embrasse's privacy officer regarding any questions I may have.

*

_____ _____

Patient Signature Date

_____ _____

Embrasse Staff Signature Date

CONSENT FOR MEDICATION

Antidepressants

Indications: SSRIs have been shown to be effective in a number of disorders including depression, obsessive-compulsive disorder, impulse control disorders, post-traumatic stress disorder, borderline personality disorder and eating disorders.

Potential side effects and risks: Common side effects from SSRIs include anxiety, insomnia, gastrointestinal symptoms (such as nausea and diarrhea), headache, decreased appetite and sexual dysfunction (such as delayed orgasm and decreased libido). Other general adverse effects may include lethargy, fatigue, sweating, tremor and other extrapyramidal side effects.

Mood Stabilizers

Indications: Anticonvulsants Gabapentin (Neurontin), lamotrogine (Lamictal), topiramate (Topramax), tiagabine (Gabitril), and ethosuximide (Zarontin), are anticonvulsants usually reserved for the treatment of bipolar patients, including the gold standards lithium, or valproate. Lithium is an element and is the lightest of the alkali metals similar to sodium, potassium, magnesium, and calcium. Lithium is available as a carbonate (Li2CO3) for oral use in rapidly acting capsules and tablets (eskalith, lithonate and lithotabs), slow-release tablets (lithobid), controlled-release tablets (eskalith CR) tablets. Lithium citrate is also available as a syrup. ithium is effective in bipolar disorder, schizoaffective disorder, major depressive disorder, schizophrenia and impulse control disorders. There is also research data on some effectiveness for premenstrual dysphoric disorder, intermittent explosive behaviors in borderline personality disorder, bulimia nervosa and episodic or binge drinking. Research data also shows lithium's benefit in treating aggressive or self-injurious behavior.

Valproate has been shown to be effective in the treatment of acute mania in bipolar disorder patients. Valproate is also an effective prophylactic treatment in the control of manic and depressive episodes. Literature studies have highlighted valproate's efficacy, especially with the subgroup of rapid cycling bipolar patients

Potential side effects and risks: The most common adverse effects for these medications are somnolence, ataxia and dizziness, which occur 20 to 30 % of the time. Tolerance may develop if the dose is increased slowly and by taking the drug with meals.

Antipsychotics

Indications: effective in the treatment of schizophrenia and other psychotic disorders. The other psychotic disorders would include schizophreniform disorder, brief psychotic disorder, delusional disorder, psychotic disorder NOS, schizoaffective disorder, manic episodes, and major depressive episodes with psychotic features.

Potential side effects and risks: headache, fever, back pain, postural hypotension, weight gain, joint pain, dizziness, rhinitis, pharyngitis, nervousness, and non-aggressive objectionable behavior. Antipsychotics are associated with minimal parkinsonism and minimal akathisia. Dystonia occurs rarely among patients treated with olanzapine; and the incidence of dyskinesia is significantly lower than with traditional antipsychotics. Antipsychotics are associated with somnolence. Patients who are involved in the operation of hazardous machinery/cars should be cautioned on this side effect until they are certain that it does not impair their motor or cognitive skills. Mild anticholinergic side effects, including blurred vision, dry mouth, constipation, urinary retention, and tachycardia, may occur secondarily.

Benzodiazepines

Indications: The major clinical application for benzodiazepines in psychiatry is the treatment of anxiety - generalized anxiety, panic disorder with agoraphobia, panic disorder without agoraphobia and anxiety associated with specific life events. Most patients should be treated for a specific and relatively brief period. A minority of patients may require long-term maintenance with these medications.

Potential side effects and risks: The most common adverse effect of benzodiazepines is drowsiness. Some patients also experience ataxia and dizziness. The most serious adverse effects of benzodiazepines occur when other sedative drugs such as alcohol, are taken concurrently. These combinations can result in marked drowsiness, disinhibition and even respiratory depression.

Psychostimulants

Indications: stimulants are a class of medications that may help you overcome the difficulty you may have paying attention, being calm or following instructions. Medications such as dextroamphetamine (Dexedrine), amphetamine (Adderall), methylphemidate (Ritalin, Concerta, Metadate, Methylin), dexmethylphenidate (Focalin) and pemolne (Cylert), can help you to be less distracted, concentrate better, and stabilize impulsive tendencies.

Potential side effects and risks: decreased appetite, irritability, increased heart rate, upset stomach, insomnia, and headaches are the most common side effects.

My physician/nurse and I discussed:

1. The nature of my mental condition.
2. My physician's reasons for prescribing the medication, including the likelihood of my condition improving or not improving without the medicine.
3. My right to refuse any medication at any time, but it is recommended that I discuss my decision with my physician before I stop taking any medication.
4. Reasonable alternative treatments available for my condition.
5. The type of medication, frequency, range, dosage, method by which I take the medication, and duration of treatment.
6. The common side effects of this medication and any particular side effects specific to the medication.
7. Information regarding the recommended medication. I understand that the information is not completely comprehensive, but it covers more common items significant to my case.
8. My medical problems and medications prescribed to me with the doctor.
9. Obtaining additional medication and drug information from my pharmacist or Physician's Desk Reference (PDR).
10. The medication(s) in Medication List
11. I understand and give consent to take the medication listed above, which is an FDA approved medication, although its use in my condition may not always appear as an indication in the labeling.

Patient/Guardian Name Patient/ Guardian Signature Date

Physician/Nurse Name Physician/Nurse Signature Date

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.

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

B. When Embrasse May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this treatment center will, consistent with its legal obligations, not use or disclose health information which identifiesyou without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. *Right to Request Special Privacy Protections.* You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. *Right to Request Confidential Communications.* You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. *Right to Inspect and Copy.* You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. *Right to Amend or Supplement.* You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. *Right to an Accounting of Disclosures.* You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

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

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

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

Region IX - Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 (fax)
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

NOTICE OF PRIVACY PRACTICES

Embrasse
550 W. Vista Way, Suite 103, Vista, CA
(760)295-8727

This notice describes how health 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 confi dentiality of your medical information. We make a record of the health 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 treatment centerproperly. 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.

A. How Embrasse May Use or Disclose Your Health Information

The health record is the property of this medical practice, but the information in the health record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. *Treatment*. We use health information about you to provide your medical care. We disclose health information to our employees and others who are involved in providing the care you need. For example, we may share your health 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 health 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 health 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 health information about you to operate this treatment center. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications so four 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 health reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your health information with our "business associ-ates," 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 confidentialityandsecurityofyour health information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clear-inghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specificallyrequiredorpermittedbylaw.Wemay 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.

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

7. *Marketing*. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive fi nancial 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 refillyourmedication 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 fi n a n c i a l compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. *Sale of Health Information.* We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. *Required by Law.* As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. *Public Health.* We may, and are sometimes required by law to, disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. *Health Oversight Activities.* We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. *Judicial and Administrative Proceedings.* We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. *Law Enforcement.* We may, and are sometimes required by law, to disclose your health information to a law enforcement officialforpurposessuchasidentifyingoflocatingasuspect, 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 agreed 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 officersthat have you in their lawful custody.

19. *Worker's Compensation.* We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. *Change of Ownership.* In the event that this treaatment center 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

PATIENT UPDATE FLOWSHEET

Cures Check:

- ☐ **N/A**

Date:	**Date:**	**Date:**	**Date:**

Signed Med Consent	**Med List Print Out**	**Pharmacy Change (if needed):**
☐ **Yes** ☐ **N/A**	☐ **Yes** ☐ **N/A**	

Vital Signs

Date:	**Blood Pressure**	**Pulse**	**Temperature**	**Weight (lbs)**

Patient Updates notes__Questions/Checks:

- *** Medication Issues, side effects, changes, or complaints since last visit**
- *** Hospitalizations since last visit or in the last 6 months or since last visit**
- *** Other concerns or issues**

DATE NOTES

PATIENT UPDATE FLOWSHEET

Cures Check:

☐ **N/A**

Date:	**Date:**	**Date:**	**Date:**

Signed Med Consent	**Med List Print Out**	**Pharmacy Change (if needed):**
☐ **Yes** ☐ **N/A**	☐ **Yes** ☐ **N/A**	

Vital Signs

Date:	**Blood Pressure**	**Pulse**	**Temperature**	**Weight (lbs)**

Patient Updates notes__Questions/Checks:

* **Medication Issues, side effects, changes, or complaints since last visit**
* **Hospitalizations since last visit or in the last 6 months or since last visit**
* **Other concerns or issues**

DATE NOTES

ADMIN DOCUMENTS__LEFT SIDE
(Filing order from newest to oldest, by category)

☐ **NOTES**
- ☐
- ☐
- ☐

☐ **DEMOGRAPHIC**
- ☐
- ☐ Change Demographic
- ☐ Original Demographic

☐ **MISCELLANEOUS**
- ☐
- ☐
- ☐ COVID-19 Liability Release Waiver
- ☐ Notification of Privacy Practice

☐ **FINANCE**
- ☐
- ☐
- ☐ Financial Agreement
- ☐ Administrative Fee--Addendum to Financial Agreement
- ☐ Copy of client's ID (*If **minor**, **Parent's/Guardian's/Guarantor's ID** is required*)
- ☐ Insurance card
- ☐ Pre-authorizations for Insurance
- ☐ Insurance Related Documents
- ☐ VOB
- ☐ Single Case Agreement (SCA)
- ☐ Statements
- ☐ Payment Plan
- ☐ Collection Notice
- ☐ Payment Authorization (*if **third party** payment, both **Patient & card holder** need to Sign the form)*
- ☐ E-Superbill Form

CLINICAL DOCUMENTS__RIGHT SIDE
(Filing order from newest to oldest, by category)

☐ **NOTES:**
- ☐
- ☐

☐ **VITALS & MEDICATIONS:**
- ☐ Patient Update Flowsheets
- ☐ Medication List/Print Out
- ☐ CURES
- ☐ Medication Administration Log
- ☐

☐ **MISCELLANEOUS:**
- ☐
- ☐ Case Management Notes
- ☐ Dr. Letters
- ☐ EDD/Disability…

☐ **HEALTH HISTORY**
- ☐ Discharge Document
- ☐ Lab
- ☐ Depression Scale
- ☐ Clinical Opiate Withdrawal Scale (COWS)
- ☐ ADHD SRS
- ☐ Patient's Prior Medical Documents
- ☐ Health Questionnaire

☐ **AUTHORIZATION/CONSENT**
- ☐ Pre-Authorization for Medication
- ☐ Authorization & Consent for Drug Testing
- ☐ Consent for Buprenorphine/Naloxone Treatment
- ☐ Consent for Medication
- ☐ Notification of Supervision
- ☐ Health Information & Medical Release Form