PULMONARY MEDICINE, INFECTIOUS DISEASE AND CRITICAL CARE CONSULTANTS
MEDICAL GROUP, INC.

Leaders in outcomes oriented, evidence based, compassionate, cost effective care

NEW PATIENT INFORMATION

Hello,
We are delighted that you have scheduled an appointment with Pulmonary Medicine, Infectious Disease, and Critical Care Consultants Medical Group. We are honored to participate in your health care.

PMA providers care for some of the most complicated and critically ill patients in the Greater Sacramento Area, both in area hospitals and in the outpatient office environment in three locations. PMA providers are specialists in pulmonary diseases, infectious diseases, sleep medicine, hyperbaric oxygen treatment, palliative care, and critical care medicine. PMA providers are Board Certified.

Our goal is to provide you with exceptional medical care and superior service. To help ensure you have the best possible visit, we offer a few tips:

1. Please completely fill out the attached Demographic and Health History Questionnaire prior to your arrival for your first appointment. If you have completed all the requested paperwork prior to your appointment, please arrive at least 30 minutes prior to your scheduled appointment time. If you are unable to complete the required paperwork prior to your appointment, you must arrive 60 minutes prior to your scheduled time or your appointment may be rescheduled. We know that sounds like a long time, but PMA providers would like to ensure that they have as much information about you as needed to provide you with exceptional medical care.

2. Please bring in all current medications or a complete list of all prescription and over-the-counter medications you are taking, along with all dose and frequency information.

3. Write down your questions or issues that you would like to cover with the doctor during your visit so you won't forget to ask and your time will be well spent.

4. Please bring your insurance card(s) and photo identification. We are required to verify the identity and insurance eligibility of all of our patients. We are also required to collect any co-payments and/or deductibles at the time services are provided.

5. Bring cash, check or credit card for your co-payment or deductible.

If you are unable to keep your appointment for any reason, please notify us at least 24 hours in advance to avoid a $50 missed appointment fee. We have set aside your appointment time just for you.

Should any questions or concerns arise before your next visit with us, please feel free to contact PMA's Central Scheduling Office by calling (916) 679-3590. We are available Monday through Friday from 8:00 a.m.-4:30 p.m and closed for lunch from 12:00 p.m. -1:00 p.m.

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Allergy & Immunology

Thank you for choosing PMA to participate in your medical care. We are committed to providing the best possible medical care to our patients while also minimizing administrative costs. This financial policy has been established with these objectives in mind, and to prevent any misunderstanding or disagreement concerning payment for professional services.

All Patients are financially responsible for services provided by Pulmonary Medicine Associates

- PMA requires that you provide a copy of your current insurance card and photo ID at every visit.
- PMA participates with numerous insurance plans. For patients who are covered by one of these insurance plans, our billing office will submit a claim for our services, directly to your insurance.
- As a requirement of both PMA and your insurance company, Co-payments are due at the time of service.
- Payment of Co-Insurance or any charges not covered by your plan is required at the time of service.
- Payment is required in full at the time of service from uninsured patients, unless arrangements have been made with the Business Office in advance.
- Payment for services can be made with cash, check or credit card.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled due to lack of referral or authorization.
- PMA charges a missed appointment fee of $50 if you do not come to your appointment for any reason, unless you cancel the appointment at least 24 hours in advance. Insurance does not cover this administrative fee. You will receive a bill. **Please note, if you are scheduled for any desensitization/rush immunotherapy and you cancel within 2 weeks of your appointment date, there will be a $100 fee.**
- Any account over 90 days old will be turned over to a collection agency unless arrangements have been made with the Business Office, and any payment plan is up-to-date.
- Our staff members are happy to answer insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. However, specific coverage issues can only be addressed by the insurance company member services department. You can find this phone number on your insurance card.

Pulmonary Medicine Associates firmly believes that a good physician-patient relationship is based upon mutual understanding and good communication. All questions and communication about financial arrangements should be directed to the central billing office (916) 482-7623, option 1. We are happy to help you.

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Date:_____

Patient

Last Name | First Name | Middle | Social Security No.

Mailing Address: Street | Apt. | City | State | Zip

Date of Birth | ☐Male ☐Female Sex | ☐ YES ☐ NO Pregnant | Marital Status

Home Phone | Work Phone | Cell Phone

E-mail Address | Preferred Method of Contact

Referring Doctor – Last Name, First | Primary Doctor - Last Name, First

Preferred Pharmacy (name and address) | Preferred Diagnostic Lab (name and address)

Preferred Imaging Facility (name and address)

Responsible Party/Guarantor

☐Same as patient

Last Name | First Name | Relationship to Patient

Home Phone | Date of Birth | E-mail

Mailing Address: Street | Apt. | City | State | Zip

Spouse Or Parent (if patient is a minor)

Last Name | First Name | Relationship to Patient

Date of Birth | ☐ Male ☐ Female Sex | Social Security No.

Home Phone | Cell Phone | Email

Primary Insurance

Insurance Company Name	Billing Address	Billing Phone
Group Number	Policy or ID Number	Effective Date

Secondary Insurance

Insurance Company Name	Billing Address	Billing Phone
Group Number	Policy or ID Number	Effective Date

Emergency Contact

In addition to being my emergency contact, I authorize PMA to communicate with the individual listed below regarding any medical and/or financial issues.

Name		Relationship
Home Phone	Work Phone	Cellular Phone

I HEREBY AUTHORIZE MEDICAL TREATMENT FOR THE ABOVE INDIVIDUAL BY PULMONARY MEDICINE, INFECTIOUS DISEASE AND CRITICAL CARE CONSULTANTS. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE ABOVE NAMED PROVIDER, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO INSURANCE CARRIERS.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF INSURED, PARENT OR LEGAL AGENT	DATE

THE FEDERAL GOVERNMENT REQUIRES PMA TO ASK ABOUT OUR PATIENT'S RACE AND ETHNICITY:

RACE:

- ☐ African American
- ☐ Asian
- ☐ White
- ☐ African
- ☐ Alaska Native
- ☐ American Indian
- ☐ Bahamian
- ☐ Bangladeshi
- ☐ Black or African American
- ☐ Burmese
- ☐ Cambodian
- ☐ Chinese
- ☐ Dominica Islander
- ☐ Dominican
- ☐ European
- ☐ Filipino
- ☐ Haitian
- ☐ Hmong
- ☐ Indonesian
- ☐ Iwo Jiman
- ☐ Jamaican
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Madagascar
- ☐ Malaysian
- ☐ Micronesian
- ☐ Middle Eastern
- ☐ Native Hawaiian
- ☐ Nepalese
- ☐ Okinawan
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Pakistani
- ☐ Polynesian
- ☐ Singaporian
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Tobagoan
- ☐ Trinidadian
- ☐ Vietnamese
- ☐ West Indian
- ☐ Decline to Respond

ETHNICITY:

- ☐ Central America
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic/Latino
- ☐ Latin American
- ☐ Mexican
- ☐ Not Hispanic or Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard
- ☐ Decline to Respond

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ALLERGY, ASTHMA AND IMMUNOLOGY

ALLERGY SKIN TESTING PREPARATION INSTRUCTIONS

During your visit, allergy skin tests may be performed to help determine your suspected allergy (food, environmental such as pollens & trees, and insect). This type of in office test is quick and very well tolerated, even by small children. However, in order to be able to obtain accurate results, you must stop taking your antihistamines a certain amount of time before your test date.

Antihistamines to be stopped 5 days prior to your appointment:

- Brompheniramine *(Actifed, Atrohist, Dimetapp, Drixoral)*
- Cetirizine *(Zyrtec, Zyrtec D)*
- Chlorpheniramine *(Chlortrimeton, Deconamine, Kronofed A, Novafed A, Rynatan)*
- Clemastine *(Tavist, Antihist)*
- Cyproheptadine *(Periactin)*
- Desloratidine *(Clarinex)*
- Dexchlorpheniramine *(Polaramine)*
- Diphenhydramine *(Allernix, Benadryl, Nytol)*
- Doxylamine *(Benectin, Nyquil)*
- Fexofenadine *(Allegra, Allegra D)*
- Hydroxyzine *(Atarax, Vistaril)*
- Levocetirizine *(Xyzal)*
- Loratadine *(Claritin, Claritin D, Alavert)*
- Meclizine *(Antivert, Dramamine)*
- Promethazine *(Phenergan)*

Note: Antihistamines are found in many over the counter medications including Tylenol PM, Actifed Cold and Allergy, Alka-Seltzer Plus Cold with Cough Formula, motion sickness medications, sleep aids, and many others. Make sure to read the ingredients carefully for all medications you are taking in the days prior to your skin test appointment.

Nasal Sprays and Eye Drops to be stopped at least 2 days prior to your appointment:

- Azelastine *(Astelin, Astepro, Dymista, Optivar)*
- Bepostastine *(Bepreve)*
- Ketotifen *(Zaditor, Alaway)*
- Olopatadine *(Pataday, Patanase)*
- Pheniramine *(Visine A, Naphcon A)*

Note: There is no need to stop steroid nasal sprays such as Flonase (fluticasone), Nasonex, Nasacort (triamcinolone), Rhinocort, and Veramyst as these medications **will not affect the skin test**.

Antacids to be stopped at least 2 days prior to your appointment:

- Cimetidine *(Tagamet)*
- Famotidine *(Pepcid)*
- Nizatidine *(Axid)*
- Ranitidine *(Zantac)*

Do not consume any products containing green tea for at least 2 weeks prior to your appointment.

*Please let us know if you are taking any tricyclic medications (antidepressants) such as amitriptyline, doxepin, imipramine, etc.

DO NOT STOP YOUR ASTHMA MEDICATIONS!

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ALLERGY, ASTHMA AND IMMUNOLOGY HEALTH HISTORY QUESTIONNAIRE

We are delighted that you have scheduled an appointment with a Pulmonary Medicine Associates Medical Group provider. To help ensure that you receive the very best care and service, we would like to know more about you and your health history. Please take the time to answer all of the questions on the following pages. We look forward to seeing you at your scheduled appointment – Be sure to bring this completed form with you.

Name: _____ Birthdate: _____

Primary Care Physician: _____ Referring Provider: _____

Specialists involved in your care:

_____

_____

_____

1. **Please describe your current medical problem (reason for your visit):**

2. **Medication(s) you are allergic to with <u>type of reaction and severity</u> for each:**
   (Ex: Advil, Itching, Mild)

3. **Current Prescription and Over-the-Counter Medications (please list strength, dosage and frequency): (Ex: Lisinopril 10 mg 1 tablet daily)**

PATIENT'S VACCINES

TdaP (Tetanus, Diphtheria, Pertussis)	**Last Date**:	
MMR (Measles, Mumps, Rubella)	☐ Yes	☐ No
H. Flu	**Last Date:**	
Pneumonia Shot (Pneumovax)	**Last Date:**	☐ I have not had this shot
Pneumonia Shot (Prevnar13)	**Last Date:**	☐ I have not had this shot
Current Season Flu Shot	**Last Date:**	☐ Decline/Refuse Shot ☐ I have not had this shot

PATIENT'S FAMILY MEDICAL HISTORY (please check yes to all that apply)

☐ I don't know my family's medical history

	Mother	Father	Brother	Sister
Autoimmune Disease	☐Yes	☐Yes	☐Yes	☐Yes
Food Allergies	☐Yes	☐Yes	☐Yes	☐Yes
Hay Fever	☐Yes	☐Yes	☐Yes	☐Yes
Hives	☐Yes	☐Yes	☐Yes	☐Yes
Recurrent Infections	☐Yes	☐Yes	☐Yes	☐Yes
Eczema	☐Yes	☐Yes	☐Yes	☐Yes
Angioedema	☐Yes	☐Yes	☐Yes	☐Yes

PATIENT'S SOCIAL HISTORY

Smoking Status (Choose One)		
☐ Never Smoker		
☐ Former Smoker	**Quit Date:**	How much did you smoke?
☐ Current Every Day Smoker		How much do you smoke?
☐ Current Some Day Smoker		How much do you smoke?
☐ Smoker - Current Status Unknown		
☐ Unknown If Ever Smoked		
Is there someone in the house who smokes?	☐Yes	Who?
Total Years of Tobacco Use?		
Chewing Tobacco Use? ☐Yes How much?	☐1/day	☐2-4/day ☐5+/day

PATIENT'S SOCIAL HISTORY (CON'T)

Present Job Type of Work:		
Have you ever been exposed to Fumes/Chemicals/Dust?	☐Yes	☐No
Have you ever been exposed to Radiation/X-Ray	☐Yes	☐No
Have you been exposed to Asbestos or Known toxic Materials?	☐Yes	☐No
Are you married? ☐Yes ☐No		
Do you have children? ☐Yes ☐No		
Where were you born?		
Have you lived in different geographic regions for over one year?	☐Yes	☐No
If YES, Where?		
What is your level of education?		
What are your major activities and hobbies?		
Do you have any household pets? ☐Yes ☐No		
Deaf or have serious difficulty hearing?	☐Yes	☐No
Blind or serious difficulty seeing?	☐Yes	☐No
Difficulty concentrating, remembering, or making decisions?	☐Yes	☐No
Difficulty walking or climbing stairs?	☐Yes	☐No
Difficulty dressing or bathing?	☐Yes	☐No
Difficulty doing errands alone?	☐Yes	☐No
Do you drink coffee or Caffeinated Beverages? ☐Yes ☐No		
If YES, how many cups per day?		
Do you exercise regularly? ☐Yes ☐No		
Do you drink alcohol? ☐Yes ☐No		
Do you live in a house, apartment or trailer? :		
Where is the home located (check all that apply) ☐Rural ☐City ☐Near factories or industries ☐Near a river/stream/ocean		
How old is the home?		
How long have you lived there?		
Has there been any water leakage or damage in your home?	☐Yes	☐No
Do you have HEPA filters?	☐Yes	☐No
Do you have a fireplace?	☐Yes	☐No
Do you have a wood burning stove?	☐Yes	☐No
Do you have carpet in your home?	☐Yes	☐No
Do you have a feather pillow and/or comforters?	☐Yes	☐No
Do you have pillow and mattress dust-proof encasements?	☐Yes	☐No

PATIENT'S SURGICAL HISTORY (mark "yes" to all that apply)

Procedure	YES
Abdominal (Belly)	
Cancer	
Cardiovascular (Heart or Blood Vessels)	
Orthopedic (Bones or Joints)	
Pulmonary (Lungs)	

PATIENT'S PAST MEDICAL HISTORY (mark "yes" to all that apply)

	YES
Anemia or Blood Disorder	
Asthma	
Blood Clot	
Bronchitis/COPD/Emphysema	
Cancer	
Diabetes	
Hay Fever or Allergies	
Heart Trouble	
High Blood Pressure	

	YES
Kidney Disease	
Liver Disease	
Musculoskeletal Disease	
Stroke	
Sleep Apnea	
Tuberculosis	
Hospitalizations	
Any Other Chronic Illness	

Please indicate "yes" if the patient has had any of the following conditions:

	YES
Constitutional	
Fever	
Weight Change	

	YES
Eyes	
Itching	
Epiphora (Watery Eyes)	
Scleral Injection (Red Eyes)	

	YES
Head	
Trauma	

	YES
Ears	
Ear "Popping"	
Itching Of The Ears	

	YES
Nose	
Sinus Pressure	
Nasal Congestion	
Sneezing	
Nasal Itching	

	YES
Throat	
Itching throat	
Post-nasal drip (PND)	
Voice Change	

	YES
Cardiovascular	
Irregular heartbeat	
High Blood Pressure (Hypertension)	
Heart Murmurs	

	YES
Respiratory	
Wheezing	
Cough	
Shortness of Breath	
Chest Tightness	
Exercise Intolerance	
Nocturnal Awakenings	
Aspirin/NSAIDs Cause Wheezing / Shortness of Breath / Nasal Congestion	
Ever been intubated for asthma?	

	YES
Gastrointestinal	
Nausea	
Vomiting	
Constipation	
Diarrhea	
Belching (Eructation)	
Abdominal Pain	
Flatulence	
Bloating	
Constant feeling of need to pass stool (Tenesmus)	
Frothy, floating, foul smelling stool (Steatorrhea)	

	YES
Psychiatric	
Irritability	
Mood Swings	
Hallucinations	

	YES
Skin	
Rash	
Hives	
Itching (Pruritus)	
Eczema	
Psoriasis	

	YES
Hematologic/Lymphatic	
Swollen Glands	
Easy Bruising	

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Five Medical Plaza, #190
Roseville, CA 95661-3037
Telephone: (916) 786-7498
Fax:(916) 786-2715

6403 Coyle Ave #450
Carmichael, CA 95608-6335
Telephone: (916) 482-7621
Fax: (916) 972-7734

1485 River Park Drive, #200
Sacramento, CA 95815
Telephone: (916) 325-1040
Fax: (916) 669-4100

Business Office
Telephone: (916) 482-7623
Fax: (916) 488-7432

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.

If you have any questions about this notice, please contact the Office Coordinator at the medical office where you receive care from a PMA provider at the numbers listed above.

WHO WILL FOLLOW THIS NOTICE

This notice describes Pulmonary Medicine Associates' (PMA) practices and that of

- Any health care professional authorized to enter information into your PMA chart
- All departments of PMA
- All employees, staff, and other PMA personnel
- All contracted Business Associates of PMA

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment, or health care operations purposes described in this notice.

PMA'S PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at PMA. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by PMA, whether made by PMA personnel or your personal doctor. This notice will tell you about the ways in which we use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private (with certain exceptions);
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that are currently in effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use of disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment
We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other PMA personnel who are involved in taking care of you. For example, a PMA doctor treating you for a wound infection may need to know if you have diabetes because diabetes may slow the healing process. The doctor may need to tell your primary care provider so that they can arrange for wound care supplies to be ordered for you. We also may disclose medical information about you to people outside PMA who may be involved in your care such as skilled nursing facilities, infusion centers, or home health agencies.

For Payment
We may use and disclose medical information about you so that the treatment and services you receive at PMA may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a bronchoscopy provided by a PMA physician so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

For 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 a billing service, that performs administrative services for PMA. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, healthcare clearing houses or health plans that have a relationship with you, when they request this information to help them with their quality review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification, or licensing activities of their health care fraud and abuse detection and compliance efforts.

Individuals Involved in Your Care or Payment for Your Care
We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care.

Research
Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients compared to those who received another, for the same condition. All research projects, however, are subject to special approval processes. These processes evaluate a proposed research project and its use of medical information, trying to balance the research needs with patient's needs for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through the approval processes, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave PMA. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at PMA.

As Required by Law
PMA will disclose medical information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety
We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Military and Veterans
If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders, and dependent adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement
We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at a PMA location;
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Food and Drug Administration (FDA)
We may disclose to the FDA your health information relating to adverse events with respect to food, nutritional supplements, products, and product defects or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Device Manufacturers
If you receive a medical device that is implanted or which is used for life support functions, we may disclose your name, address, and other information as required by law to the device manufacturer for tracking purposes. You may refuse to authorize the disclosure of your name and contact information.

Business Associates
There are some services provided in our organization through contracts with business associates. Examples include our electronic health record storage, surveying for patient satisfaction, and a scanning service we use when storing copies of your billing information. When these services are provided by contracted business associates, we may disclose the appropriate portions of your health information to our business associates so they can perform the job we have asked them to do. To protect your health information, however, we require all business associates to sign a confidentiality agreement verifying they will appropriately safeguard your information.

Coroners, Medical Examiners and Funeral Directors
We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of PMA physicians to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary, 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to PMA Medical Records Department at the office where you received your care. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by PMA will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend
If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for PMA. To request an amendment, your request must be made in writing and submitted to the PMA Medical Records Department at the office where you received your care. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by PMA, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for PMA;
- is not part of the information which you were permitted to inspect and copy; or
- is accurate and complete

Even if your request is denied, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment, and health care operations, (as those functions are described above) and with other expectations pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to the PMA Medical Records Department at the office where you received your care. Your request must state the time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to receive notification whenever a breach of your unsecured protected health information occurs.

Right to Request Restrictions
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

> ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to PMA Medical Records Department at the office where you received your care. In your request, you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to restrict PMA from disclosing certain protected health information from your health plan as long as you are paying for your care in full out of pocket, and you request such a restriction. You must make such restriction requests as noted in the paragraph above.

Right to Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you must make your request in writing to PMA Medical Records Department at the office where you received your care. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Website: www.pmamed.com. To obtain a copy of this notice by mail, contact PMA Patient Services at 916-679-3590.

Changes to This Notice
PMA reserves the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on our Website. This notice will contain at the bottom of each page the effective date. In addition, each time you register at PMA for health care services, we will offer to provide a copy of the current notice in effect.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with PMA, or with the Secretary of the Department of Health and Human Services. To file a complaint with PMA, submit your complaint to the PMA Privacy and Security Officer, at the office where you received your care. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice or the laws that apply to PMA will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Physicians in California are required to inform their patients that they are licensed by the Medical Board of California and to provide to patients the Board's contact information:

NOTICE TO CONSUMERS
Medical Doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Signature below is only acknowledgement that you have received this Notice of PMA's Privacy Practices and the Medical Board Consumer Notice:

Signature: _____ Date: _____

Print Name: _____

At Pulmonary Medicine Associates we understand you have many choices in your health care. We would like to say thank you for choosing us and remind you to please be kind to your lungs.