Eva Poon, M.D., Inc.
675 S. Arroyo Pkwy, Suite 110
Pasadena, CA 91105

PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name: _____First: _____M.I.:____ Gender:___

SSN:_____ Date of Birth: _____Driver's License#:_____

Address:_____ City: _____State: ____ Zip:_____

Home #:_____Cell#: _____Email:_____

Occupation:_____Employer:_____Phone:_____

Ethnicity_____Preferred language (if not English)_____

Pharmacy (name, location or phone #)_____

INSURANCE INFORMATION

Who referred you to our office? (Doctor, friend, online)_____

Primary Insurance Plan:_____ Phone:_____

Policy ID#:_____Group #_____PCP Copay:_____

Policy Holder's name:_____SSN:_____DOB:_____

Secondary Insurance Plan:_____Phone:_____

Policy ID#:_____Group #_____PCP Copay:_____

Policy Holder's name:_____SSN:_____DOB:_____

EMERGENCY CONTACT:

Emergency contact:_____Relationship:_____Phone:_____

Nearest Relative (not living with you)_____Phone:_____

HIPAA INFORMATION: Instructions for office when communicating with patient.

I authorize the office to contact me at: □ Home, □ Work, □ Cell.

I authorize the office to leave detailed messages: □ Yes □ No.

Patient Signature:_____Date:_____

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Patient Financial Responsibilities and Policies

The following outline of financial responsibilities and consent policies have been established to assist us in providing the highest quality medical care and outline possible disclosures of health information for treatment, payment, and patient healthcare options.

Missed appointments: Since we are reserving treatment time for you, our policy is to charge a cancellation fee for appointments not canceled at least 24 hours in advance. These charges will be your responsibility and billed directly to you.

Payment policy: Excepting medicare patients, payment is expected at time services are rendered, including those with insurance. Cash, check, or credit card is accepted.

Insurance: We are only contracted with Medicare. We are out of network for PPO insurances. Your insurance coverage and benefits is a contract between you and your insurance company; we are not party to the contract. Therefore, it is your responsibility to understand your coverage and benefits. Patients are responsible for all fees that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received.

As a courtesy, for patients with insurance, we will file your insurance forms from our office. If insurance payments are made directly to our office, your account will be credited. Please make sure your insurance and demographic information is kept up to date with our office. At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.

Returned Check: There will be a thirty dollar ($30.00) charge assessed for any check returned by your bank for any reason.

Collections: Accounts that are not paid within sixty (60) days from the date of service may be sent to our collections department. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records: We will provide a digital or analog copy of your medical records upon request for a twenty-five dollar ($25.00) administrative fee. You will be required to sign a medical record release form and pay the medical record fee in full prior to having your medical records copied. Please allow up to one (1) week for this request to be processed.

Health Forms: Forms are completed for those whose accounts are in good standing. Turnaround time for form completion is usually 10 business days. Please complete patient name and demographic information. Form completion is not reimbursed by insurance. Charges for form completion varies with duration of physician involvement and time and will be determined by the physician. The minimum charge for review and/or completion of any health form is $25 per page. Family/Medical Leave Act and Disability forms are $100. DMV forms are $50. Rush service may be available for an additional fee of $35. Forms must be paid for before they are released.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally abusive or physically abusive to staff
- Failure to meet financial obligations

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- Failure to see Dr. Poon for a physical in >24 months.

A certified letter will be sent to your last known address notifying you that you are being dismissed from Dr. Poon's practice. If you have a medical emergency within thirty (30) days of the date of the letter, Dr. Poon will see you. After the thirty (30) days, you will no longer be seen by Dr. Poon. A copy of your medical record may be forwarded to your new doctor after formal request is made and appropriate fees are paid.

Patient Acknowledgement:
I,_____(print name) have read and agree to the Patient Financial Responsibilities and Policies. I agree to pay at the time of service. I also understand that Eva Y. Poon, M.D. Inc. reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

_____

Patient signature **Date**

Eva Y. Poon, M.D., Inc
675 S. Arroyo Parkway Suite 110
Pasadena, CA 91105 626-243-5211

Date

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	**DOB**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:** **Date of last labs:**

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ COVID date:

☐ Acid Reflux	☐ Emphysema/Chronic Bronchitis (COPD)	☐ Kidney Disease, Type:
☐ Allergies (seasonal)/hay fever	☐ Epilepsy/Seizures	☐ Kidney stones
☐ Anemia	☐ Gallstones	☐ Liver Disease, Type:
☐ Anxiety/Panic attacks	☐ Glaucoma	☐ Migraines
☐ Asthma	☐ Gout	☐ Obesity
☐ Autoimmune Diseases	☐ Headache	☐ Osteoarthritis
☐ Back Pain	☐ Heart attack	☐ Osteoporosis
☐ Bleeding from Bowels	☐ Heart murmur	☐ Prostate Problems
☐ Bleeding Problems, Type:	☐ High Blood Pressure	☐ Skin Problems, Type:
☐ Blood clot	☐ High Cholesterol/Triglycerides	☐ Strokes, Type:
☐ Cancer, Type:	☐ Irregular Heart Beat/Arrhythmia	☐ Thyroid Problems
☐ Congestive heart failure	☐ Irritable Bowel Syndrome	☐ Urinary incontinence
☐ Depression	☐ Insomnia	☐ Other:
☐ Diabetes	☐ Joint Pain	☐ Other:

Please list all physicians whose care you are currently under

Physician name	Specialty/Location	Physician name	Specialty/Location
Physician name	Specialty/Location	Physician name	Specialty/Location

Surgeries		
Year	Reason	Hospital

Other hospitalizations			
Year	Reason	Hospital	
Have you ever had a blood transfusion?		☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins or herbs		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
☐ No known drug allergies		
Name the Drug	Reaction	

PREVENTIVE CARE			
Immunizations	**Dates**	**Immunizations**	**Dates**
Meningococcal		HPV	
TDaP/Td/DTAP (most recent)		Pneumococcal	
Hepatitis A		Chickenpox	
Hepatitis B		Shingles	
Influenza (most recent)		MMR	

WOMEN		**MEN**	
Vision Screen Last Date	Results?	Vision Screen Last Date	Results?
Colonoscopy Last Date	Have you ever had an abnormal result? If so, please indicate date	Colonoscopy Last Date	Have you ever had an abnormal result? If so, please indicate date
Bone Density Scan Last Date	Results?	Bone Density Scan Last Date	Results?
Mammogram Last Date	Have you ever had an abnormal result? If so, please indicate date	Prostate Exam Last Date	Have you ever had an abnormal result? If so, please indicate date
Breast Exam Last Date	Have you ever had an abnormal result? If so, please indicate date	PSA Level Checked Last Date	Have you ever had an abnormal result? If so, please indicate date
PAP/Pelvic Exam Last Date	Have you ever had an abnormal result? If so, please indicate date		
Date of last menstrual period	Hormone use		
Number of pregnancies	Number of Live births		

SOCIAL HISTORY				
Exercise	Type			
	Frequency			
	Duration (in minutes)			
Alcohol	(Number of) drinks per week/month			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	Type ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars ☐ Other			
	Frequency (in packs or #/day)			
	Duration	Number of years	☐ Quit? Year _____	
Drugs	Type			
	Frequency			
	Duration			
Sex	Are you sexually active?		☐ Yes	☐ No
	Partner gender preference			
	Current form of birth control			
Other	Current (and/or previous) occupation(s)			
	What is your living situation? ☐ Alone ☐ with family ☐ with pets ☐ single story building ☐ multi-story building			
	What is your highest level of education?			

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	M F	
Mother				M F	
Sibling	M F			M F	
	M F			M F	
	M F		**Grandmother** Maternal		
	M F		**Grandfather** Maternal		
	M F		**Grandmother** Paternal		
	M F		**Grandfather** Paternal		

Consent to Use Telemedicine

Patient's Name_____ My Doctor's Name_____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

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Physician-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

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The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

If any provision of this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

_____	_____	_____
Signature of Patient	Printed name of Patient	Date
_____	Eva Y. Poon	_____
Signature of Physician	Printed name of Physician	Date

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Notice of Privacy Practices
Effective date: 3/1/2018

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) require that our practice provide you with this notice regarding privacy of your PHI.

This notice describes:
- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

Revision or amendments of this notice

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

The use and disclosure of PHI

The following categories describe the different ways in which we may use and disclose your PHI:

1. **Treatment**. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may

contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health care operations**. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

<u>The use and disclosure of your PHI permitted without authorization</u>

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
2. **Public health risks**. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths,
    - Reporting child abuse or neglect,
    - Preventing or controlling disease, injury or disability,
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
    - Reporting adverse reactions to drugs,
    - Notifying individuals if a product or device they may be using has been recalled,
    - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
3. **Health oversight activities**. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities

necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

4. **Lawsuits and similar proceedings**. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
5. **Law enforcement**. We may release PHI if asked to do so by law enforcement:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
    - Concerning a death we believe has resulted from criminal conduct,
    - Regarding criminal conduct at our offices,
    - In response to a warrant, summons, court order, subpoena or similar legal process,
    - To identify/locate a suspect, material witness, fugitive or missing person,
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
6. **Deceased patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
7. **Organ and tissue donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
8. **Serious threats to health or safety**. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to the health and safety of an individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military**. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National security**. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates**. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' compensation**. Our practice may release your PHI for workers' compensation and similar programs.
13. **Disaster Relief.** Our practice may disclose your PHI to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.

Your rights regarding your PHI

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Dr. Eva Poon 626-508-3388** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
2. **Requesting restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Dr. Eva Poon 626-508-3388** Your request must describe in a clear and concise fashion:
    - The information you wish restricted,
    - Whether you are requesting to limit our practice's use, disclosure or both,
    - To whom you want the limits to apply.
3. **Inspection and copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Dr. Eva Poon 626-508-3388** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Dr. Eva Poon 626-508-3388.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-

routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Dr. Eva Poon 626-508-3388.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a paper copy of this notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Dr. Eva Poon 626-508-3388**
7. **Right to file a complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Dr. Eva Poon 626-508-3388.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to provide an authorization for other uses and disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Privacy Officer

If you have any questions regarding this notice or our health information privacy policies, please contact **Dr. Eva Poon at 626-508-3388.**

I, _____, have received a copy of this policy.

Patient Signature_____Date_____

Eva Poon, M.D., Inc.
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Pasadena, CA 91105

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I _____ (Patient name)_____(DOB) hereby authorize my health care provider:

Physician/Hospital name: _____
Address:_____
Phone:_____Fax:_____

to use or furnish the following medical information about the undersigned during the term of this Authorization to the recipient(s) that I have identified below:

Dr. Eva Poon
675 S. Arroyo Parkway, Suite 110
Pasadena, CA 91105
Phone: 626-508-3388
Fax: 626-508-3399

PURPOSE: I authorize the release of my health information for the following specific purpose:

_____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

INFORMATION TO BE DISCLOSED: I authorize the release of the following health information:

- ❑ All of my health information that the provider has in his or her possession, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and alcohol abuse records, and HIV test results, if any.

- ❑ Only the following records or types of health information:
  - ❑ Any laboratory results from the previous 12 months.
  - ❑ Any imaging results from the previous 5 yers.
  - ❑ Records of any screening or diagnostic tests (e.g. colonoscopy, DEXA, mammograms, PAP smears, biopsies, EKGs)
  - ❑ Recoreds of any consultations from the previous 5 yers
  - ❑ A recent progress note, if available.
  - ❑ Other_____.

I understand that I may be charged a reasonable fee for photocopying and/or transmittal of these records.

I understand that this Authorization will remain in effect for 30 days from the date it is signed.

Patient Signature:_____**Date**:_____