MONTEREY PSYCHIATRIC CENTER

INTAKE INFORMATION - PLEASE PRINT CLEARLY – THANK YOU		
Today's Date	Insurance Authorization #	Date of Birth
Last Name	First Name	Middle Initial
Sex: ❒ Male ❒ Female	Social Security Number:	
Address:		
City, State, & ZIP:		
Phone :	Home: Cell: Work:	
Email Address:		
Referred by:		
Current Symptoms:		
Current Medication:		
Prior Psychiatric History:		
Medication History:		
Health Information:		
Psychological Symptoms:	❒ None ❒ Anxiety ❒ Depression ❒ Suicidal ❒ Homicidal ❒ Delusional ❒Hallucinations	
Cardiovascular:	❒ None ❒ Chest pain ❒High blood pressure ❒ Irregular heartbeat ❒ Pacemaker	
Respiratory:	❒None ❒ Wheezing ❒ Shortness of breath ❒Frequent Cough ❒Asthma	
Gastrointestinal:	❒ None ❒ Abdominal pain ❒ Nausea ❒ Vomiting ❒ Diarrhea ❒ Indigestion ❒ Heartburn	
Neurological:	❒ None ❒ Tremors ❒ Dizzy spells ❒ Numbness ❒ Tingling ❒ Epilepsy	
Endocrine:	❒ None ❒Excessive thirst ❒ Too hot ❒ Too Cold ❒ Tired ❒ Hearing Difficulty	
Allergies:		

Financial Agreement

I understand and agree that Health Insurance Policies are arrangements between my insurance company and me. Monterey Psychiatric Center and/or its billing agents will provide information to assist me in collecting payment from my insurance company. I understand and agree that I am responsible for payment for all services rendered. I understand that payment, in full, is due at the time of service. I understand that if I fail to notify Monterey Psychiatric Center within 24 hours of an appointment cancellation that I will be responsible for payment in full for the missed appointment. I hereby consent to treatment by Monterey Psychiatric Center and its practitioners.

Responsible Party Signature Date

415 Figueroa Street ◆ Monterey, CA 93940 ◆ 831.372.6008 ◆ fax 831.656.0330 ◆info@monterey-psychiatric.com

INSURANCE INFORMATION (Please provide a copy of all insurance cards)

Primary Insurance Carrier	
Address: Street, City, State, & Zip	
Policy & Group Number (s)	
Name of Policy Holder	
Policy Holder's Social Security #	
Policy Holder's Relationship to Patient	
Secondary Insurance Carrier	
Address: Street, City, State, & Zip	
Policy & Group Number (s)	
Name of Policy Holder	
Policy Holder's Social Security #	
Policy Holder's Relationship to Patient	

PERSONAL INFORMATION

❑ Single	❑ Married	❑ Separated	❑ Divorced	❑ Widow

Please Complete Regarding Spouse or Significant Other:	
Name:	Employer:
Phone:	Employer's Address:
Date of Birth: SS#:	
Email:	

CONFIDENTIALITY STATEMENT – HIPPA COMPLIANCE

The HIPPA Privacy Rule mandates the protection and privacy of all health information. This rule specifically defines the authorized uses and disclosures of "individually-identifiable" health information. Information relating to a patient's psychiatric history, diagnosis, condition, treatment, or evaluation is considered individually identifiable health information. The privacy of all psychiatric records and other individually identifiable health/psychiatric information will be protected at all times.

In full compliance with the law, confidentiality of health and personal information will be maintained at all times, and only disclosed with the express written consent of the patient.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a notice/copy of the Monterey Psychiatric Center / Dr. Joseph Greene's Privacy Practices.

Signature of Patient/Legal Guardian or Patient Representative Date

Relationship to Patient (if applicable)

COMPLETE THIS SECTION IF PATIENT IS A MINOR			
Mother's Name	Date of Birth		Social Security Number
Mother's Employer	Employers Address		Mother's Work Phone
Father's Name	Date of Birth		Social Security Number
Father's Employer	Employers Address		Father's Work Phone
Name of School	School Address		School Phone Number
School Contact	Contact Phone #	School Nurse	School Nurse Number/Fax Number
Current Grade	Boarding School	Other Information	

CUSTODY			
❒ Joint Physical	❒ Joint Legal	❒Sole Physical	❒Sole Legal & Physical
❒Mother ❒Father	❒Mother ❒Father	❒Mother ❒Father	❒Mother ❒Father
❒ Other	❒ Other	❒ Other	❒ Other

AUTHORIZATION TO TREAT A MINOR

MINOR'S NAME IN FULL	DATE OF BIRTH

I/we, the undersigned parent(s), legal guardian(s) of the minor person listed above do authorize the physicians, nurses, and therapists of the Monterey Psychiatric Center to provide health, psychiatric, and therapeutic services to this minor in the presence and in the absence of a parent or legal guardian. These services may include, but are not limited to: examination, prevention, and/or curative treatments, laboratory examination, medical/psychiatric diagnosis, and any consultation deemed necessary at the physician's, nurse's, and therapist's direction. It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician, nurse, and therapist to exercise his or her best judgment as to the requirements of such diagnosis or medical and psychiatric treatment in my or our absence. This consent shall remain in affect until revoked, in writing, by parent(s) or legal guardian(s), or until the child may legally consent for him or herself.

Signature of Parent or Legal Guardian	Date

Office Policies

Fees, Appointments, and Insurance

Monterey Psychiatric Center maintains a strict 24-hour cancellation policy for all appointments. Patients are responsible to pay in-full for appointments which are cancelled with less than 24-hour notice. If appointment is on a Monday, appointment must be cancelled by noon on the Friday before.

Initials ___

Therapy appointments are typically made on a regular basis: weekly, bi-weekly, or monthly. Once a schedule is agreed upon, we reserve that time for you. This establishes a contract for the doctor's or therapist's time for your scheduled appointment. Therefore, in accordance with the above stated policy, you are responsible for payment for appointments that are cancelled with less than 24-hour notice. If advance notice of 24-hours or more is given, or we are able to schedule another patient for your appointment time, we will not hold you financially responsible. This policy applies to group therapy sessions as well.

Fees are due at the time of service. Please be prepared to pay for services at each visit. For your convenience we accept cash, check, and Visa or Master Card credit cards.

Initials ___

Exception: Patients who have Community Health Plan insurance administered by Coastal (CHOMP employees), Aetna or Guardian (SVMH employees) are obligated only to pay their 'co-pay' at the time of service. If for any reason, the above stated insurance company denies coverage, your account will be payable and due at once.

For all other insurances, it is the responsibility of the patient to pay at the time of service. Patients are responsible to submit payment reimbursement with their insurance company, if desired. Monterey Psychiatric Center provides patients with appropriate documentation for submitting claims to their insurance company. I understand that should I elect to submit claims to my insurance company, it is my responsibility to verify and comply with any restrictions and/or limitations contained in my medical or psychiatric insurance coverage.

Initials___

All accounts 60 days and older will be assessed a $12.00 late fee. Accounts in excess of 90 days may be referred to an outside collection agency. There is a $25.00 service charge for all returned checks. Your (or your Parent/Guardian's) signature below constitutes an understanding of this policy and waiver of confidentiality for the purposes of fee collection.

Signature of Patient (or of Parent/Legal Guardian) Date

Print Name of Patient or Legal Guardian

MONTEREY PSYCHIATRIC CENTER

Authorization for Credit Card Payment

I authorize Monterey Psychiatric Center to charge the credit card indicated below for all balances and charges incurred for the patient(s) listed. I further understand that if my credit card company does not accept the charge, I will immediately make payment to the practice for the services rendered and balance due.

INITIAL:_____

I ACKNOWLEDGE AND ACCEPT, THAT THE ABOVE CREDIT CARD INFORMATION WILL BE CHARGED FOR FEES IN-FULL IF I FAIL TO GIVE 24-HOUR NOTICE TO CANCEL AN APPOINTMENT, OR IF I MISS MY INITIAL APPOINTMENT. I FURTHER ACKNOWLEDGE AND ACCEPT THAT ALL FUTURE BILLING CAN BE CHARGED TO MY CREDIT CARD IF PAYMENT IS NOT RECEIVED AT THE TIME OF SERVICE, IF APPOINTMENTS ARE MISSED OR CANCELLED WITH LESS THAN 24-HOUR NOTICE, IF INSURANCE DOES NOT COVER CHARGES, AND/OR FOR ANY OUTSTANDING BALANCES.

INITIAL:_____

I can revoke this authorization at any time, with written notice. I acknowledge and understand that if this authorization is revoked, any current balances and/or future balances and charges will need to be paid in full by cash, check, money order or alternative credit card.

Type of Card:	❒ Visa	❒ MasterCard			
Account Number:			Expiration:	VCODE (back of card):	
Name of Cardholder:			Home/Cell Numbers:		
Billing Address:			Billing Zip Code:		
Driver's License #:		Exp: / /	Name of Patient(s):		
Authorized Signature:			Date		

Please Note: Credit card information is required to schedule all new patient appointments, or an alternative payment method must be arranged.

MONTEREY PSYCHIATRIC CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I (Patient or Legal Guardian) _____ , hereby authorize

- ☐ MONTEREY PSYCHIATRIC CENTER
- ☐ JOSEPH B. GREENE, M.D.
- ☐ DAVID ZUCCOLOTTO, Ph.D., P.A.
- ☐ PATRIZIA AHLERS, MA
- ☐ ALL OF THE ABOVE

To share or exchange information with the individual/organization listed below, and for the below listed individual/organization to share or exchange information.

_____
NAME (INDIVIDUAL OR ORGANIZATION) TITLE (REQUIRED)

_____
ADDRESS CITY (REQUIRED) STATE ZIP

_____ _____
PHONE NUMBER FAX NUMBER

I further release the above cited individual or agencies from any obligation of confidentiality that they may have with Monterey Psychiatric Center and its associates in order to provide for a free discussion or exchange of information with the parties/agencies named above and visa versa.

I hereby authorize for the release/sharing of the following information:

- ☐ Verbal Discussion
- ☐ Results of psychological and/or educational testing
- ☐ Summary of psychiatric evaluation and/or treatment and results
- ☐ Report of most recent physical/laboratory examinations
- ☐ Summary of medical/psychological/psychiatric/therapeutic treatment
- ☐ School records, including description of school behavior, information on academic performance and the results of testing/grades.
- ☐ Other _____
- ☐ All of the above

This authorization expires on:
☐ No expiration (This authorization may be revoked at any time with written notification) ☐ Date _____

_____ _____
PATIENT SIGNATURE (IF RESPONSIBLE PARTY) DATE PARENT OR LEGAL GUARDIAN DATE

MOOD DISORDER QUESTIONAIRE (MDQ)

INSTRUCTIONS:
Please answer each question as best you can.

Has there ever been a period of time when you were not your usual self and …

		YES	NO
1	__ you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
	__ you were so irritable that you shouted at people or started fights or rguments?	☐	☐
	__ you felt much more self-confident than usual?	☐	☐
	__ you got much less sleep than usual and found that you didn't really miss it?	☐	☐
	__ you felt much more talkative or spoke much faster than usual?	☐	☐
	__ thoughts raced through your head or you couldn't slow your mind down?	☐	☐
	__ you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
	__ you had much more energy than usual?	☐	☐
	__ you were much more active or did many more things than usual?	☐	☐
	__ you were much more social or outgoing than usual, for example you telephoned friends in the middle of the night?	☐	☐
	__ you were much more interested in sex than usual?	☐	☐
	__ you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
	__ spending money got you or your family in trouble?	☐	☐

2 If you checked **YES** to more than one of the above…
have several of these ever happened during the same period of time?

3 How much of a problem did any of these cause you – like being unable to work; having family, money or legal trouble; getting into arguments or fights?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious Problem

415 Figueroa Street ◆ Monterey, CA 93940 ◆ 831.372.6008 ◆ fax 831.656.0330 ◆info@monterey-psychiatric.com

The following statement is required by the Medical Board of California. In order to be compliant with the regulation, the patient or responsible party must sign and date below. A signed original will be maintained in the patient's chart.

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

_____ _____

Patient Name – please print Patient or Responsible Party Signature

Date: _____

Updated: January 23, 2012

About our Office

Monterey Psychiatric Center offers a full range of child, adolescent, adult, and geriatric psychiatric services. We employ a Psychiatrist, Marriage and Family Therapists, and Interns who specialize in mental health care. Our Center focuses on the diagnosis and treatment of psychiatric, addictive, and emotional disorders. Conditions can include depression, anxiety disorders, substance-abuse disorders, behavioral disorders, schizophrenia, Bipolar disorders, and others.

The first step for effective treatment is a comprehensive evaluation and assessment of a patient and/or the family. Traditional psychotherapy, psychopharmacology, explorative, and supportive therapies are available through our center. Treatment modalities include individual therapy, family therapy, marriage counseling, medication education groups, and group therapy. Monterey Psychiatric Center practitioners work with the patient to develop an individualized treatment plan which addresses the complex components of mental health. Appointments are set based on the treatment goals and may range from weekly sessions to monthly sessions or on an as-needed basis.

Hours of Operation

Therapy and/or psychopharmacology appointments are scheduled, based on your needs, Monday through Friday, from 8:15 am to 7:00 pm. The administrative office (appointments, billing, etc) is staffed Monday through Thursday from 8:00 am – 5:00 pm, and Friday from 8:00am – 12:00pm. The office is closed Monday through Thursday from 12:00 – 1:00 for lunch, during which time phones are not answered.

Children and Adolescents:

The practitioners at the Monterey Psychiatric Center specialize in the diagnosis and the treatment of disorders of thinking, feeling, and/or behavior affecting children, adolescents, and their families.

The child and adolescent psychiatrist uses knowledge of biological, psychological, and social factors in working with patients. Initially, a comprehensive diagnostic examination is performed to evaluate the current problem with attention to its physical, genetic, developmental, emotional, cognitive, educational, family, peer, and social components. Once a diagnosis has been determined and presented to the family, the psychiatrist designs a treatment plan that considers all of the above components and discusses these recommendations with the child or adolescent and his or her family. An integrated approach may involve individual, group or family psychotherapy; medication; or consultation with other physicians or professionals from schools, juvenile courts, or other community based organizations. In addition, the practitioners at Monterey Psychiatric Center are prepared and expected to act as an advocate for the best interests of children and adolescents.

Depression in Children and Teenagers:

Children and teenagers may have depression, which is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function in school or in life.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attention, learning, conduct or anxiety disorders are at a higher risk for depression.

Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their children.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Hopelessness

- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

Psychiatric Medication for Children and Adolescents:

Psychiatric medications can be an effective part of the treatment for psychiatric disorders of childhood and adolescence. In recent years there have been an increasing number of new and different psychiatric medications used with children and adolescents. Research studies are underway to establish more clearly which medications are most helpful for specific disorders and presenting problems. Clinical practice and experience, as well as research studies, help physicians determine which medications are most effective for a particular child. Before recommending any medication, the psychiatrist (preferably a child and adolescent psychiatrist) should conduct a comprehensive diagnostic evaluation of the child or adolescent. Medication therapies are based on the patient's presenting psychiatric symptoms, past response to medications, and consideration of possible side effects. Psychiatric medication should only be used as part of a comprehensive treatment plan.

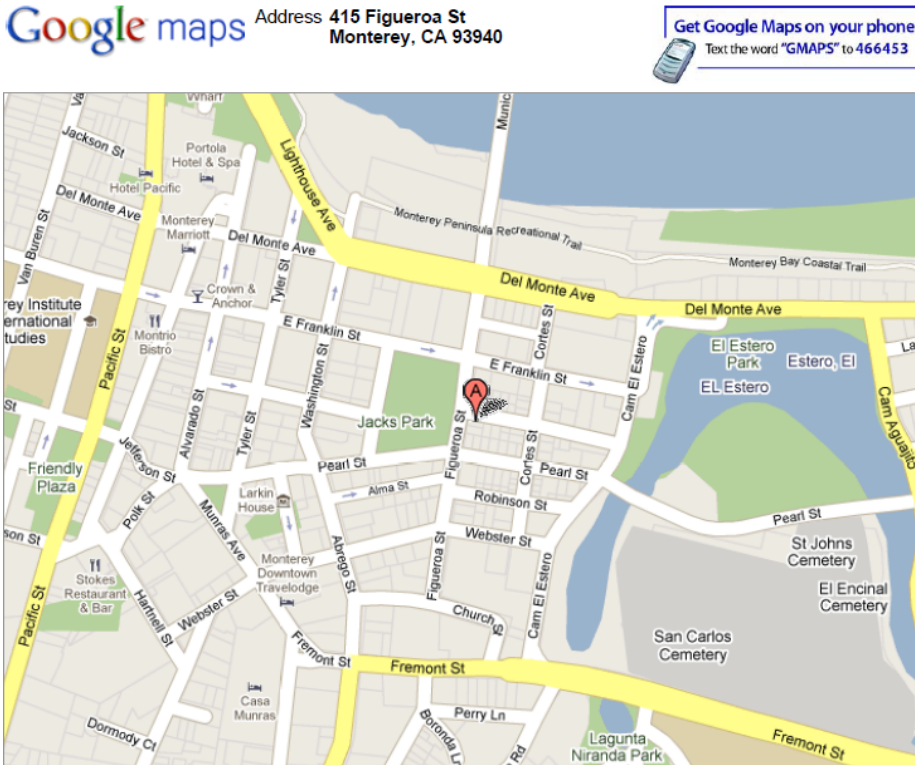
A doctor's recommendation to use medication often raises many concerns and questions in both the parents and the patient. The physician who recommends medication should be experienced in treating psychiatric illnesses in children and adolescents. He or she should fully explain the reasons for medication use, what benefits the medication should provide, as well as unwanted side-effects and other treatment alternatives.

Psychiatric medication should not be used alone. As undertaking a medication trial may mean adjusting doses of medicine over time and/or the use of additional medications to meet an individual patient's needs, the use of medication should be part of a comprehensive treatment plan, usually including psychotherapy, as well as parent guidance sessions.

Before recommending any medication, the child and adolescent psychiatrist interviews the patient and makes a thorough diagnostic evaluation. In some cases, the evaluation may include a physical exam, psychological testing, laboratory tests, other medical tests such as an electrocardiogram (EKG) or electroencephalogram (EEG), and consultation with other medical specialists.

Child and adolescent psychiatrists stress that medications which have beneficial effects may also have unwanted side effects, ranging from just annoying to very serious. As each patient is different and may have individual reactions to medication, close contact with the treating physician is recommended. Do not stop or change a medication without speaking to the doctor. Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing *medical assessment* and, in most cases, *individual and/or family* psychotherapy.

When prescribed appropriately by a psychiatrist (preferably a child and adolescent psychiatrist), and taken as prescribed, medication may reduce or eliminate troubling symptoms and improve the daily functioning of children and adolescents with psychiatric disorders.



Monterey Psychiatric Center is located at 415 Figueroa Street, on the corner of Figueroa and Anthony Streets. The office beige with red and green trim and I located directly across from Jack's Park where the tennis courts and baseball field meet.

PRIVACY NOTICE

Privacy Officer: Joseph Greene, M.D., 415 Figueroa Street, Monterey, CA 93940
Phone: 831-372-6008

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them 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, 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 efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you to all the other health care providers who participate in any health care operations activities of **Monterey Psychiatric Center.**

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign-in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. 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 in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a

disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. 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.

9. 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.

10. 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.

11. 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 proceedings 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.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. 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.

16. Specialized government functions. We may disclose your heath information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. 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.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. 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.

20. Fundraising. We will not disclose your demographic information or the dates that you received treatment for fundraising activities.

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

Except as described in the Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your 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 e-mail account or to your work address. We will attempt to 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 and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, 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. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

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 disclosure 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 16 (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 a paper copy of this Notice of Privacy Practices.

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 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 will offer you a copy at each appointment.

E. Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.