

Lubna Isho D.O. Inc.
250 W. Bonita Ave. Suite 150
Pomona, CA 91767
Tel: (909) 392 4747
Fax: (909) 392 4767
www.drisho.com

How did you hear about us?

Newspaper
 Social media/Web search
 Insurance directory
 Family/Friend

Patient Registration

PATIENT INFORMATION									
NAME (LAST, FIRST, M.I.)				SSN			BIRTHDATE		
LANGUAGE		PRIMARY CARE PROVIDER			CURRENT GENDER MALE FEMALE UNDIFFERENTIATED				
BILLING ADDRESS (STREET, APT OR UNIT #)				CITY			STATE	ZIP	
PHYSICAL ADDRESS (IF DIFFERENT FROM BILLING ADDRESS)				CITY			STATE	ZIP	
CELL PHONE XXX-XXX-XXXX		HOME PHONE XXX-XXX-XXXX		DAY PHONE XXX-XXX-XXXX		EMAIL ADDRESS (EXAMPLE@TEST.COM)			
PREFERRED CONTACT METHOD (REQUIRED) CELL HOME DAY EMAIL		MARITAL STATUS		MOTHER'S MAIDEN NAME		RACE		ETHNICITY	
EMERGENCY CONTACT NAME						PHONE NUMBER XXX-XXX-XXXX			
PRIMARY EMPLOYER				SECONDARY EMPLOYER (If applicable)					
ADDRESS (STREET, SUITE#)				ADDRESS (STREET, SUITE#)					
CITY, STATE, ZIP				CITY, STATE, ZIP					
WORK PHONE XXX-XXX-XXXX		OCCUPATION		WORK PHONE XXX-XXX-XXXX		OCCUPATION			
POLICYHOLDER/GUARANTOR (If different than patient)									
NAME (LAST, FIRST, M.I.)				SSN			BIRTHDATE		
LANGUAGE		PRIMARY CARE PROVIDER			CURRENT GENDER MALE FEMALE UNDIFFERENTIATED				
BILLING ADDRESS (STREET, APT OR UNIT #)				CITY			STATE	ZIP	
PHYSICAL ADDRESS (IF DIFFERENT FROM BILLING ADDRESS)				CITY			STATE	ZIP	
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PREFERRED CONTACT METHOD (REQUIRED) CELL HOME DAY EMAIL		MARITAL STATUS		MOTHER'S MAIDEN NAME		RACE		ETHNICITY	
RELATIONSHIP TO PATIENT									
PRIMARY INSURANCE									
NAME OF INSURANCE COMPANY					POLICY #				
NAME OF POLICY HOLDER		DOB	RELATIONSHIP TO PATIENT		GROUP #	COPAY AMT \$	DEDUCTIBLE AMT \$		
ADDRESS OF INSURANCE COMPANY (STREET, SUITE #, CITY, ST, ZIP)				PHONE XXX-XXX-XXXX		EFFECTIVE DATE		EXPIRATION DATE	
SECONDARY INSURANCE									
NAME OF INSURANCE COMPANY					POLICY #				
NAME OF POLICY HOLDER		DOB	RELATIONSHIP TO PATIENT		GROUP #	COPAY AMT \$	DEDUCTIBLE AMT \$		
ADDRESS OF INSURANCE COMPANY (STREET, SUITE #, CITY, ST, ZIP)				PHONE XXX-XXX-XXXX		EFFECTIVE DATE		EXPIRATION DATE	

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Lubna Isho, DO Inc. to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Lubna Isho, DO.

 PATIENT/GUARDIAN SIGNATURE

 DATE

 RELATIONSHIP TO PATIENT

PATIENT FINANCIAL AGREEMENT

- **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.
- **Deductible Payments:** If your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A \$150.00 payment will be due at the time of service. Please note the \$150.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.
- **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Preventive Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services.
- **Cash Pay Patients:** The amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, x-ray tests, any injections, special procedures or additional office visit charges.
- **Missed appointments:** Please note a \$25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

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

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

Patient or Guardian Signature: _____ *Date:* _____

Patient Name (please print) _____ *Date of Birth:* _____

**ACKNOWLEDGEMENT OF
RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Lubna Isho, DO Inc.

I hereby acknowledge that I have been offered a copy of Notice of Privacy Practices. I have been advised that any amended Notice of Privacy Practices will be available at each appointment.

PATIENT NAME (please print)

PATIENT DATE OF BIRTH

PATIENT/GUARDIAN SIGNATURE

DATE

PATIENT PHONE XXX-XXX-XXXX

NAME OF PHYSICIAN

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Beneficiary or personal representative of deceased patient

I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is: _____

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Lubna Isho, DO Inc to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
Guardian	_____	_____
Caregiver	_____	_____
Sister	_____	_____
Brother	_____	_____
Friend	_____	_____
Emergency Contact	_____	_____
Other	_____	_____

You may discuss my (please check all that apply)

Visit Notes Laboratory Results X-rays Reports All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print) _____ Patient Date of Birth _____
Patient/Guardian Signature _____ Date _____

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE

PATIENT NAME	TODAY'S DATE
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PATIENT DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	NAME OF SPOUSE/SIGNIFICANT OTHER
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SOCIAL HISTORY

BIRTHPLACE	PATIENT'S OCCUPATION
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NATIONALITY	EDUCATION
-------------	-----------

RELIGION	MARITAL STATUS	# YEARS?
----------	----------------	----------

RECREATIONAL DRUG USE? TYPE YES NO	CHILDREN
---	----------

TOBACCO USE? TYPE YES NO	
-----------------------------------	--

# PACKS PER DAY	# YEARS	LAST USED	PETS
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ALCOHOL USE? TYPE YES NO	# DRINKS	per	Day	Week	Month	EXERCISE TYPE YES NO	HOW OFTEN?
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IF HEAVY USE, HOW MANY YEARS?	LAST USED	RECENT OR FREQUENT TRAVEL DESTINATIONS
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CAFFEINE USE? TYPE YES NO	# CUPS / DAY	
------------------------------------	--------------	--

MEDICAL CONDITIONS

Have YOU ever had (check appropriate boxes):

Cancer / Type _____ Heart attack Coronary artery disease Rheumatic fever Heart failure High blood pressure High cholesterol Stroke Diabetes Gallstones Liver disease Hepatitis/Jaundice Ulcer disease Heartburn / Reflux Asthma Seizures	Emphysema Pneumonia Tuberculosis Positive TB skin test Osteoporosis Arthritis Gout Frequent bladder infection Kidney stones Kidney disease Polio Chicken pox Infectious mono Anemia Frequent sinus infections	Glaucoma Thyroid issues Hives Depression Head injury Broken bones Blood transfusions Sexually transmitted diseases: Herpes, HIV, etc. Gonorrhoea, Chlamydia Syphilis Intravenous drug abuse Needle injury Mumps Migraines	Prostate enlargement Cystic fibrosis Malaria Other: _____ IMMUNIZATIONS Measles, Mumps and Rubella Vaccine Chicken Pox Vaccine Hepatitis B Vaccine Influenza Vaccine Pneumococcal Vaccine Tetanus Booster
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PAST SURGICAL HISTORY (If applicable, please check the box and enter the year)

	YEAR		YEAR		YEAR
Eyes (laser or vision corrected)	_____	Gall bladder	_____	Spinal surgery/back	_____
Eyes (cataract/glaucoma)	_____	Intestine/colon	_____	Orthopedic (hips/knees)	_____
Ears	_____	Hemorrhoids	_____	Shoulders/feet/hands	_____
Sinus/nasal septum	_____	Hernia	_____	C-Section	_____
Tonsils/adenoid	_____	Breast	_____	Vasectomy	_____
Thyroid	_____	Uterus/hysterectomy	_____	Tubal ligation	_____
Heart	_____	Ovaries	_____	OTHER _____	_____
Stomach	_____	Spinal surgery/neck	_____		_____
Varicose veins	_____	Prostate	_____		_____

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH
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CURRENT MEDICATIONS

NAME	DOSE	TIMES/DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Allergies or adverse reactions to medications? _____

FAMILY MEDICAL HISTORY

Has anyone in your FAMILY ever had any of the following (check appropriate boxes and list relationship):

	Relationship		Relationship		Relationship
Cancer/Type _____	_____	Dialysis	_____	Crohn's/colitis	_____
Diabetes	_____	Chronic lung disease	_____	Alzheimer's	_____
Cardiac/dysrhythmia	_____	Tuberculosis	_____	Alcoholism	_____
Congestive heart failure	_____	Rheumatoid arthritis	_____	Bleeding tendency	_____
Coronary artery disease	_____	Thyroid issues	_____	Anemia	_____
Valvular heart disease	_____	Osteoporosis	_____	Gout	_____
High blood pressure	_____	Cystic fibrosis	_____	Depression	_____
High cholesterol	_____	Asthma	_____	Mental illness	_____
Stroke	_____	Peptic ulcer	_____	Seizures	_____
Kidney stones	_____	Gallstones	_____	Migraine headaches	_____
Kidney disease	_____				
OTHER _____					Relationship _____

GYNECOLOGICAL / OBSTETRICAL HISTORY

Name of OB/GYN (please print): _____

Age when you started menstruating: _____ Number of pregnancies: _____

Date of last Pap smear: _____ Number of births: _____

History of abnormal Pap smears? Yes No Vaginal C-Section

Date of last mammogram: _____ Method of contraception: _____

History of abnormal mammograms? Yes No

Menstrual cycles? Regular Irregular

Painful periods? Yes No

Age at menopause: _____

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH
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Have you been feeling any of these symptoms recently?

GENERAL

Fever Fatigue Night sweats
Other _____

METABOLIC/ENDOCRINE

Cold intolerance Heat intolerance

HEAD, EYES, EARS, NOSE & THROAT

Vision changes Headaches

NEURO/PSYCHIATRIC

Dizziness Anxiety Depression

RESPIRATORY

Shortness of breath Cough

DERMATOLOGIC

Rash Itching

CARDIOVASCULAR

Chest pain Palpitations

MUSCULOSKELETAL

Back pain Joint pain

VASCULAR

Leg cramps with exercise

HEMATOLOGIC

Easy bruising Easy bleeding

GASTROINTESTINAL

Vomiting Diarrhea Constipation

IMMUNOLOGICAL/ALLERGY

Food allergies Environmental allergies

GENITOURINARY

Burning with urine Blood in the urine

Any other symptoms not mentioned above?

ADULT HISTORY AND REVIEW OF SYMPTOMS QUESTIONNAIRE (continued)

PATIENT NAME	PATIENT DATE OF BIRTH
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PHARMACY

Your prescriptions will be sent electronically to the pharmacy of your choice. To which pharmacy may we send your prescriptions? (Please check below.)

CVS Wal-Mart Rite Aid Walgreens Target Sav-On Costco

Other: _____

Location (cross street and city): _____

Best number to reach you if we have additional questions: _____

HEALTH MAINTENANCE

When was your last physical? _____

When was your last cholesterol blood work? _____

If over age 50, when was your last colon cancer screening? _____ Sigmoidoscopy Colonoscopy

If over age 65, when was your last DEXA (bone density) screening? _____

If female, when was your last Pap smear? _____

If female over age 40, when was your last mammogram? _____

VACCINATIONS

Please list, to the best of your knowledge, the most recent date you received the following vaccine(s):

1. Tetanus _____
2. Flu vaccine (given annually from the Fall to Spring) _____
3. Pneumonia vaccine (if over 65 or certain health conditions) _____
4. Shingles vaccine (if over age 60) _____

Are you interested in receiving any of the above? Yes No

ADVANCE DIRECTIVE

Do you have an Advance Directive? Yes No

Would you like to discuss Advance Directives? Yes No

**AUTHORIZATION TO RELEASE
MEDICAL RECORDS**

**Phone: (909) 392-4747
Fax: (909) 392-4767**

Patient Name	Patient Date of Birth
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Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

FROM: _____ <i>(Disclosing physician or provider)</i>	TO: Lubna Isho, DO Inc <i>(Receiving physician or provider)</i>
_____ <i>(Street Address)</i>	250 W. Bonita Ave. Ste 150 <i>(Street Address)</i>
_____ <i>(City, State, Zip Code)</i>	Pomona, CA 91767 <i>(City, State, Zip Code)</i>

Release records and information regarding: _____
(Patient's Name)

_____ <i>(Date of Birth)</i>	_____ <i>(Social Security #)</i>	_____ <i>(Telephone Number)</i>
_____ <i>(Address, City, State, Zip Code)</i>		

DURATION: This Authorization shall become effective immediately and shall remain in effect through _____ (enter date) or for one year from the date of signature if no date entered.

REVOCACTION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

REDISCLASURE: I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

Authorization to use Email & Text Message

Patient's Printed Name: _____

I would like to communicate via: text message email both text message & email

Approved **Email Address** (print clearly): _____

patient's personal patient's work family of patient other

Name the owner of email address, if not patient: _____

Approved **Phone Number** (print clearly): _____

1. **Risk of Using Email & Text Message**

Lubna Isho D.O. Inc. offers patients or the patients' designees the opportunity to communicate by email or text message. Transmitting patient information by email or text message, however, has a number of risks that patients should consider before using email or text message. These include, but are not limited to, the following risks:

- a. Email and text messages can be circulated, forwarded, and stored in numerous paper and electronic files.
- b. Email and text messages can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- c. Senders of email and text messages can easily mis-address their message.
- d. Email and text messages are easier to falsify than handwritten or signed documents.
- e. Back-up copies of email and text messages may exist even after the sender or the recipient has deleted his or her copy.
- f. Employers and online services have a right to archive and inspect emails and text messages transmitted through their systems.
- g. Email and text messages can be intercepted, altered, forwarded, or used without authorization or detection.
- h. Email and text messages can be used to introduce viruses into computer systems.
- i. Email and text messages can be used as evidence in court.

2. **Conditions for the Use of Email & Text Message**

Lubna Isho D.O. Inc. will use reasonable means to protect the security and confidentiality of email and text message information sent and received. However, because of the risks outlined above, Lubna Isho D.O. Inc. cannot guarantee the security and confidentiality of email and text message communication, and will not be liable for improper disclosure of confidential information that is not caused by Lubna Isho D.O. Inc.'s intentional misconduct. Thus, patients must consent to the use of email and text message for patient information. Consent to the use of email and text message includes agreement with the following conditions:

- a. All emails and text messages concerning diagnoses or treatment will be printed and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record will have access to those emails and text messages.
- b. Lubna Isho D.O. Inc. may forward emails and text messages to Lubna Isho D.O. Inc. staff and agents as necessary for diagnoses, treatment, reimbursement, and other handling. Lubna Isho D.O. Inc. will not, however, forward emails and text messages to independent third parties without the patient's prior written consent, except as authorized or required by law.
- c. Although Lubna Isho D.O. Inc. will endeavor to read and respond promptly to email and text messages, Lubna Isho D.O. Inc. cannot guarantee that any particular email or text message will be read and responded to within

any particular period of time. Thus, email or text messaging should not be used for medical emergencies or other time-sensitive matters. Not all clinicians are available by text message.

- d. If an email or text message requires or invites a response from Lubna Isho D.O. Inc., and a response has not been received within a reasonable time period, it is the sender's responsibility to follow up to determine whether the intended recipient received the email or text message, and when the recipient will respond.
- e. The patient/designee is responsible for protecting his/her password or other means of access to email or text message. Lubna Isho D.O. Inc. is not liable for breaches of confidentiality caused by the patient designee or any third party.
- f. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
- g. Lubna Isho D.O. Inc. is not currently equipped to encrypt or encode email or text messages, so all email between patient/designee and Lubna Isho D.O. Inc. remains in an easily readable format that anyone would be able to read who gains access to it.

3. Instructions

To communicate by email or text message:

- a. Inform Lubna Isho D.O. Inc. of changes in email address or phone number.
- b. Do not put the patient's name in the subject line of an email.
- c. Include the category of the communication in the subject line, such as "Billing Question".
- d. Review the email or text message to make sure it is clear and that all relevant information is provided before sending to Lubna Isho D.O. Inc..
- e. Take precautions to preserve the confidentiality of emails and text messages, such as using screen savers, safeguarding computer passwords, and locking the device.
- f. Withdraw consent only by email or written communication to Lubna Isho D.O. Inc..

4. Patient Acknowledgement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication by email or text messages, and consent to the conditions outlined herein. In addition, I agree to the instructions that Lubna Isho D.O. Inc. may impose to communicate by email and text message. Any questions I may have had were answered.

Patient Name

Signature of Patient

Date:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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

A. How Lubna Isho, DO Inc May Use or Disclose Your Health Information

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

1. *Treatment.* We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.
2. *Payment.* We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. *Health Care Operations.* We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our “business associates,” such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health

information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law.

We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

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, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these 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.* Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and re-fill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. *Sale of Health Information.* We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. *Required by Law.* As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. *Public Health.* We may, and are sometimes required by law to, disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. *Health Oversight Activities.* We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. *Judicial and Administrative Proceedings.* We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. *Law Enforcement.* We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. *Coroners.* We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. *Organ or Tissue Donation.* We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. *Public Safety.* We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. *Proof of Immunization.* We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. *Specialized Government Functions.* We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. *Worker's Compensation.* We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. *Change of Ownership.* In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. *Breach Notification.* In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
22. *Research.* We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When Lubna Isho, DO Inc May Not Use or Disclose Your Health Information

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

C. Your Health Information Rights

1. *Right to Request Special Privacy Protections.* You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. *Right to Request Confidential Communications.* You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. *Right to Inspect and Copy.* You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's

records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. *Right to Amend or Supplement.* You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. *Right to an Accounting of Disclosures.* You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

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