James Ho, M.D.

1330 San Bernardino Road, Suite G, Upland, CA 91786 • (909) 755-0622 Fax: (909) 931-3627

General Information

Patient Name_____ Date of Birth_____/_____/_____ Age_____
(last) (first)

Address_____ City, State_____ Zip _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Phone ( )_____ Mobile Phone ( )_____

SS#_____-_____-_____ DL#_____

Primary language_____ Do You Need an interpreter? ☐ Yes ☐ No

How Were You Referred To Our Office? ☐ Physician ☐ Friend ☐ Insurance ☐ Ad ☐ Other

Is your visit today related to an illness or injury from your work? ☐ Yes ☐ No

Adjuster _____ Claim #_____

Employment Information

Employer_____ Phone ( ) _____

Address _____City, State_____ Zip_____

Insurance/Billing Information

Responsible Party_____Relationship_____ DOB_____

Employer of Responsible Party (if different from patient) _____

Insurance_____ Phone ( ) _____

Address_____ City, State_____ __ Zip_____

Policy Holder_____ Relation to Patient_____

Insured SS#_____Policy/Group# _____Member ID#_____

Emergency Contact: _____ Phone ( ) _____

Patient Responsibility

Due to stringent rules adopted by the Federal Government (HIPAA-Health Insurance Portability and Accountability Act) with regard to patient confidentiality, the responsibility of delivery of medical testing results and medical records will be the responsibility of the patient. Many facilities will no longer provide a copy of your medical testing or records via fax or mail without an authorization signed by you on the date it is being requested. This is for your protection but our office is unable to obtain your testing results with a phone call. It is your responsibility to assure that the results of any testing from other facilities are faxed to our office in time for your next appointment.

I authorize James Ho MD Medical Corporation to obtain medical records, testing, x-rays or any pertinent information to assist in evaluation and treatment of my medical condition. This authorization shall remain in effect for 1 (one) year unless revoked by me in writing.

_____ _____

Responsible Party **Date**

ADULT HEALTH HISTORY

Name/Nombre	Age/Edad	D.O.B./Cuando Nacio	Date/Fecha

HISTORY OF PAST ILLNESS Have you had?/ENFERMEDADES PASADAS: (Ha tenido)

Measles/Sarampion.....No Yes/Si
Mumps/Paperas.....No Yes/Si
Chickenpox/Viruela.....No Yes/Si
Diabetes.....No Yes/Si
Strokes/Embolio.....No Yes/Si
Rheumatic fever/Fiebre Reumatica.....No Yes/Si
Heart Disease/Enfermedad del Corazon.....No Yes/Si
Tuberculosis.....No Yes/Si
Venereal Disease/Enfermedad Veneria.....No Yes/Si
Serious Disease/Enfermedad Graves.....No Yes/Si

Ever Hospitalized/Ha sido hospitalisado...No Yes/Si...Explain/Explicacion_____
Ever had surgery/Ha tenido operaciones.....No Yes/Si...Explain/Explicacion_____
Had broken bones/Ha tenido fracturas.....No Yes/Si...Explain/Explicacion_____
Head concussions or injuries/
Glopes o Heridas de cabeza..... ..No Yes/Si...Explain/Explicacion_____
Date of Last Tetanus Shot/La Fecha de su ultima immunizacion de Tetno_____
Date of Last PAP Smear/La Fecha de papanicolou exam de cancer_____
Date of Last Mammogram/Mammographia_____

FAMILY HISTORY/HISTORIA FAMILIAR:

Has anyone in your family ever had?/Ha habido en su familia?

Cancer No Yes/Si...Who/Quien?_____
Diabetes No Yes/Si...Who/Quien?_____
Tuberculosis No Yes/Si...Who/Quien?_____
Heart trouble/Enfermedad del corazon No Yes/Si...Who/Quien?_____
High blood pressure/Presion alta No Yes/Si...Who/Quien?_____
Stroke/Embolio No Yes/Si...Who/Quien?_____
Convulsions/Epilepcia No Yes/Si...Who/Quien?_____
Suicide/Suicidio No Yes/Si...Who/Quien?_____

SOCIAL HISTORY/HISTORIA SOCIAL:

Single/Soltero ☐ Married/Casado ☐ Seperated/Separado ☐ Divorced/Divorciado ☐ Widowed/Viudo ☐
Alcoholic Beverages/Bebidas Alcolicas: Never/Nunca_____ How much/Cuanto_____
Tobacco or Cigarettes/Tobacco o Cigarillos: Never/Nuca_____ How much/Cuanto_____
Are you sexually active?/Esta sexualmente activa? Y ☐ N ☐
What is your job?/Cual es su trabajo?_____
Education Level/Nivel de Education:1☐2☐3☐4☐5☐6☐7☐8☐9☐10☐11☐12☐ College/Colegio Supenor: 1☐2☐3☐4☐
Ethnic Background/Nacionalidad ☐ American Indian ☐Asian ☐Filipino ☐ Pacific Islander ☐ Black ☐ Hispanic ☐ White

SYSTEMIC REVIEW GENERAL?REVISION DE SYSTEMAS:

Recent weight change/Reciente cambio de peso?..... No Yes/Si
Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida?.... No Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin/Piel.....No Yes/Si....Explain/Explicacion_____
Head-Eyes-Ears-Nose-Throat/
Cabeza-Ojos-Oidos-Nanz-Garganta.....No Yes/Si...Explain/Explicacion_____
Neck/Cuello.....No Yes/Si...Explain/Explicacion_____
Lungs/Pulmones.....No Yes/Si...Explain/Explicacion_____
Heart and Circulation/Corazon o Circulacion.....No Yes/Si...Explain/Explicacion_____
Blood/Sangre.....No Yes/Si...Explain/Explicacion_____
Emotions/Emociones.....No Yes/Si...Explain/Explicacion_____
Nerves/Nervios.....No Yes/Si...Explain/Explicacion_____
Muscles and Bones/Musculos o Huesos.....No Yes/Si...Explain/Explicacion_____
Stomach and Bowels/Estomago o Intestinos.....No Yes/Si...Explain/Explicacion_____
Sex Organs/Organos Sexuales.....No Yes/Si...Explain/Explicacion_____
Urinary/Unnanos.....No Yes/Si...Explain/Explicacion_____
Any other/Cualquiera otro.....No Yes/Si...Explain/Explicacion_____

ALLERGIES OR REACTIONS TO FOOD /MEDICATION/LATEX
ALERGIAS O REACCIONES A ALIMENTOS / MEDICINAS/LATEX_____

PATIENT SIGNATURE/FIRMA_____ DATE/FECHA_____

DOCTOR SIGNATURE_____ DATE/FECHA_____

UPLAND GROVE MEDICAL GROUP
Gregory Suelzle, M.D., Board Certified Pain Management · CApainMD.com
James Ho, M.D., Board Certified Family Practice · jhomd.com

Medications

Patient Name: _____

Allergies: _____

Pharmacy: _____

Medication Name	Dosage	Frequency

1330 San Bernardino Road, Suite B, Upland, CA 91786 • Phone (909) 981-0608 • Fax: (909) 982-5327

JAMES C. HO, M.D.MEDICAL CORPORATION

To Our Patients;

Your privacy is of utmost concern to us. Please take a moment to complete this information so that we only contact you and/or leave messages where you want.

	OK to contact you at this number To confirm, cancel or reschedule an appointment information?	Is it OK to leave a message?
1. _(_____)_____ Home Phone	☐ Yes ☐ No	☐ Yes ☐ No
2. _(_____)_____ Work Phone	☐ Yes ☐ No	☐ Yes ☐ No
3. _(_____)_____ Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No
4. _____ E-Mail Address	☐ Yes ☐ No	☐ Yes ☐ No
5. _(_____)_____ Emergency Contact	Relationship: _____	

ACKNOWLEDGEMENT OF NOTICE REGARDING PRIVACY OF INFORMATION

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to provide you, the patient, a Notice of our Privacy Practices. The notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

En conformidad con el acto de la Portabilidad y de la Responsabilidad del seguro médico de 1996 (HIPPA), nos otros es requerido que laproporcione al paciente el Aviso de la Practicas de la Privacidad. Este aviso describe cómo la información de la salud sobre usted puede ser utilizada y ser divulgada, y cómo usted puede tener el acceso a esta información. Por favor lea esta informacion cuidadosmente.

.....

I hereby acknowledge that I was given a copy of James C Ho MD Medical Corporation's Notice of Privacy Practices to read. I was also given the opportunity to have a copy to take with me if I desired. In addition, a Notice of Privacy Practices is posted in the patient waiting area.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrctions.

I would like to receive a copy of James C Ho MD Medical Corporation's Notice of Privacy Practices via e-mail

at: _____

_____ _____

Signature Date

_____

Print Name

If not signed by patient, please indicate relationship:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this receipt of Notice of Privacy Practices form but was unable to do so as documented below:

Date: Initials: Reason:

Insurance Benefit Assignment/Consent to Disclose Medical Information

Medicare - Authorization & Benefit Assignment

I request that payment of authorized **Medicare** benefits be made to James C Ho. MD Medical Corporation for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any Personal Health Information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of Personal Health Information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Name of Beneficiary HIC (Medicare Number)

Insurance - Authorization & Benefit Assignment

I hereby authorize James C Ho MD Medical Corporation to furnish Personal Health Information concerning my illness and treatment to insurance carriers or other entity necessary to pay the claim, and I hereby assign to James C Ho MD Medical Corporation all payment for medical services rendered to my dependents or myself. I understand I am responsible for patient deductibles and any amount not covered by the insurance. Laboratory, radiology and other ancillary services provided in connection with physician's office will be billed separately. Co-pays must be made at the time of service and a fee of $25.00 will be added to any returned check balances. I understand and agree to give at least 24 hours notice if I am unable to keep an appointment. Failure to do so will result in a "No-Show" charge of $25.00 added to my account balance.

_____ _____

Responsible Party Signature Date

Consent to Treatment

The undersigned consents to the treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered to the patient under the general and specific instructions of the patient's physician.

_____ _____

Responsible Party's Signature Date

Consent To Treatment of a Minor

I hereby consent to and authorize for my **minor child:**

_____ _____

Name of Minor Child Minor's Birth Date

Diagnostic and/or therapeutic treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered under the general and specific instructions of the physician. I am a legal guardian or parent with the legal authority to give consent to treatment.

_____ _____

Parent/Guardian Signature Date

Does the minor child live with you? ☐ YES ☐ NO Your phone number if different from child: _____

If divorced, name of person with legal custody of minor child _____

Patient's Rights

You may refuse to give consent and may object to any part of this form. If so, please ask to speak with us about that. If you chose to give consent in this document, you may revoke your consent in the future, in writing. This right, and other rights that you have in regard to your Personal Health Information use and disclosure are detailed in our Privacy Notice. If you did not receive a copy of this Privacy Notice, please ask for one and read it carefully. We value you as a patient and strive to achieve the highest standards in our service to you.

Identification Verified by: _____

Depression Screening Assessment

Member Name: _____ Date of Birth: _____ Member ID: _____

Depression Screening (PHQ-9)

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE - 9

	Over the last 2 weeks, how often have you been bothered by any of the following problems? *Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?*	Not at all *Ningún día*	Several Days *Varios días*	More Than Half the Days *Más de la mitad de los días*	Nearly Every Day *Casi todos los días*
1	Little interest or pleasure in doing things *Poco interés o placer en hacer cosas*	0	1	2	3
2	Feeling down, depressed, or hopeless *Se ha sentido decaído(a), deprimido(a) o sin esperanzas*	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much *Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado*	0	1	2	3
4	Feeling tired or having little energy *Se ha sentido cansado(a) o con poca energía*	0	1	2	3
5	Poor appetite or overeating *Sin apetito o ha comido en exceso*	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down *Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia*	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television *Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión*	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual *¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal*	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way *Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera*	0	1	2	3
1-4 Minimal Depression, 5-9 Mild Depression, 10-14 Moderate Depression, 15-19 Moderately Severe Depression, 20-27 Severe Depression		**TOTAL:**			

Adverse Childhood Experiences Revised Questionnaire

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Name: Date:

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
Did you lose a parent through divorce, abandonment, death, or other reason?	☐
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
Did you live with anyone who went to jail or prison?	☐
Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
Did you feel that no one in your family loved you or thought you were special?	☐
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

	I	II	III	IV
M:	0-4	5-14	15-19	20+
W:	0-3	4-12	13-19	20+

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR MEDICAL TREATMENT

A federal law requires us to give you information that explains your rights to make health care decisions and how you can plan what should be done when you can't speak for yourself.

Your doctor must tell you about your medical condition and about what different treatments are available to you. . Many treatments have "side effects". Often, more than one treatment might help you. Your doctor can tell you which treatments are available to you, but can't choose for you. That choice depends on what is important to you.

If you can't make treatment decisions, your doctor will ask your closest relative or friend to help decide what is best for you. Sometimes everyone doesn't agree about what to do. That's why it's helpful if you say, in advance, what you want to happen if you cannot speak for yourself. There are several kinds of "advance directives" that you can use to say what you want and who you want to speak for you.

One kind of advance directive under California law lets you name someone to make healthcare decisions when you can't. This form is called a ***DURABLE POWER OF ATTORNEY FOR HEALTHCARE*****.** You can choose an adult relative or friend you trust as your "agent" to speak for you when you're too sick to make your own decisions.

You can write down in the **DURABLE POWER OF ATTORNEY FOR HEALTHCARE** when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Sometimes treatment decisions are hard to make and it truly helps your family and your doctors if they know what you want. ***THE DURABLE POWER OF ATTORNEY FOR HEALTHCARE*** also gives them legal protection when they follow your wishes.

If you don't want to have anyone make decisions for you, you can use another kind of advance directive to write down your wishes about treatment. This is often called a ***LIVING WILL*** because it takes effect while you are still alive but have become unable to speak for yourself. The California Natural Death Act lets you sign a living will called a ***DECLARATION*****.** Anyone 18 years or older of sound mind can sign one.

When you sign a ***DECLARATION*** it tells your doctors that you don't want any treatment that would prolong your dying. All life-sustaining treatment would be stopped if you were terminally ill and your death was expected soon, or if you were permanently unconscious. You would still receive treatment to keep you comfortable, however.

The doctors must follow your wishes about limiting treatment or turn your care over to another doctor who will. Your doctors are also legally protected when they follow your wishes.

You can sign a ***DECLARATION***, using any of the available ***LIVING WILL*** forms, a ***DURABLE POWER OF ATTORNEY FOR HEALTHCARE*** form, or you can just write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding about your treatment. But living Wills that don't meet the requirements of the Natural Death Act don't give as much legal protection for your doctors if a disagreement arises about following your wishes. You can change or revoke any of these documents at any time as long as you communicate your wishes. Be sure to let your doctors, family, friends and any agent you may have appointed know if you decide to change or revoke your advance directive.

You do not have to fill out any of these forms if you don't want to. You can just talk with your doctors and ask them to write down what you've said in your medical chart. And you can talk with your family, but people will be clearer about your treatment wishes, and your wishes are more likely to be followed if you write them down.

If you don't have someone you want to name to make decisions when you can't, you can sign a ***NATURAL DEATH ACT DECLARATION.*** This ***DECLARATION*** says that you do not want life prolonging treatment if you are terminally ill or permanently unconscious.

We have provided you with this information concerning advance directives so that you can fully participate in planning your future health care decisions. We believe it is never too early to think about decisions that may be very important in the future, and to discuss these topics with your family, friends, and other interested people.

It is up to you to inform your primary care physician of whether or not you have completed an advance directive and provide a copy of it to them. Also, remember to bring a copy of your advance directive when you check into a hospital or other health facility so that it can be kept with your medical records.

To obtain an advance directive form, attend a workshop, or receive free assistance in completing an advance directive, you may call ***California Health Decisions*** *at:* ***714 347-7921***

NOTICE OF PRIVACY PRACTICES
James Ho, M.D. Medical Corporation
1330 San Bernardino Road, Suite G, Upland, CA 91786 909-755-0622

Effective Date September 1, 2013
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 listed above.*

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 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 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. ***[Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]***
4. [Optional: 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 have 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 refill 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 agree 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. **[Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.] [*Add the following three activities, or any of the three, only if the organization engages or intends to engage in these activities*.]**
22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. 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.
24. Fundraising. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. WHEN THIS MEDICAL PRACTICE 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 another 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 email.
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.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.
If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
Region IX, Office for Civil Rights, U.S. Department of Health & Human Services, 90 7th Street, Suite 4-100, San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD), (415) 437-8329 FAX OCRMail@hhs.gov
The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date: