PPMA
MEDICINE THE WAY IT SHOULD BE

To Our Patients:

On behalf of the entire team, we would like to welcome you to Private Physicians Medical Associates. We feel it is an honor and privilege to be entrusted with your care and will do all we can to exceed your expectations. As our partner in health, we ask you to assist us in the following ways:

Keep follow-up appointments and reschedule missed appointments:
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on times gives him the chance to check my condition and my response to treatment. During my follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. **Initial _____**

Call the office when I do not hear the results of labs and other tests:
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results. **Initial _____**

Inform my doctor if I decide not to follow his recommended treatment plan:
I understand that after my examination, my doctor may make certain recommendations based on what he feels are best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his recommendation so that he may fully inform me of any risks associated with my decision to delay or refuse treatment. Finally, I understand the importance of providing a full and complete medical history. All conditions and symptoms of which I am aware will be disclosed in my medical questionnaire. **Initial _____**

The annual concierge fee does not cover everything:
I understand that my annual concierge fee does not cover charges including but not limited to deductibles, co-payments, co-insurance, radiology exams, specialist referrals and laboratory testing. I am responsible to understand what my own personal insurance covers and cannot rely on the doctor's office to keep me informed of this information. **Initial _____**

When an office visit is inconvenient:
Telephone consults with your doctor are available for certain conditions and issues. **Initial _____**

Insurance and address change.
I will inform the office immediately when my contact information and /or health insurance has changed. **Initial _____**

Thank you for your partnership. As our patient you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature _____ Date _____ / _____ / _____

Patient Name Printed _____

520 Superior Avenue, Suite 285
Newport Beach, CA 92663
T: 949-566-8179 F: 888-565-6545 E: info@privatemds.com
www.privatemds.com

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PATIENT INFORMATION *(CONFIDENTIAL)*

Today's Date: _____ / _____ / _____ Van Meter_____Weiss_____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ / _____ / _____ Age: _____ Male: _____ Female: _____

Street Address: _____ City: _____

State: _____ Zip: _____ E-Mail _____

Home # (_____) _____ - _____ Cell # (_____) _____ - _____

Social Security #_____-_____-_____ Preferred Pharmacy:_____

Single _____ Married ____ Divorced _____ Widowed _____ Separated _____

Employer: _____

Title/Occupation: _____ Work # (_____) _____ - _____

Street Address: _____ City: _____

Spouse's Name: _____

Spouse's Employer: _____ Work # (_____) _____ - _____

Emergency contact not living with you: name_____ number _____

Do you have an advanced directive or living will? ( ) No ( ) Yes (If YES, may we have a copy?) ( ) No ( ) Yes

Optional: African American ( ) Asian ( ) Caucasian ( ) Hispanic ( ) Other ( ) _____

I HEREBY ASSIGN TO PRIVATE PHYSICIANS MEDICAL ASSOCIATES ALL BENEFITS PROVIDED BY MY INSURANCE COMPANY FOR MEDICAL CARE.

Please provide us with ALL medical insurance cards at the time of your visit.

Signature of Patient or Parent if Minor: _____ Date: _____ / _____ / _____

Print Name: _____ Relationship: _____

It is important for us to thank those who referred you to our office.

*How did you hear about us?*_____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I the undersigned hereby authorize _____
(Physician/Healthcare Facility)

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: Private Physicians Medical Associates
520 Superior Ave, Ste 285
Newport Beach, CA 92663
Attn: L. Richard Van Meter, MD &
James M. Weiss, MD
949-566-8179 (Tele) / 888-565-6545 (Fax)

The medical information/records will be used to provide me with health care goods and services.

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV diagnosis/treatment)
[ ] Limited to the following medical information:
_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV ____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment ____ (initial)

DURATION: This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of my signature.

RESTRICTIONS: Permission for further use or disclose of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall me considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
[Signature of Patient or Legal Guardian] [Date]

_____ _____
[Print Name & Relationship if Other than Patient] [Date]

_____ _____
[Patient's Date of Birth] [Patient's Social Security Number]

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Prior Records

Please provide the names and phone numbers of the physicians/medical facilities from whom we should obtain records.

1. _____
2. _____
3. _____
4. _____
5. _____

Medication List

Please provide the names of all prescription and supplemental medications that you are currently taking.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Allergies

Please list any and all allergies you have.

1. _____
2. _____
3. _____
4. _____
5. _____

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NOTICE OF PRIVACY PRACTICES

Private Physicians Medical Associates - 520 Superior Avenue, Suite 285, Newport Beach, Ca 92663
Kelly Latini, Privacy Officer tel: 949-566-8179

Effective Date: October 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 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 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. 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. 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 of 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.

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.

Health Information Exchange

This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation. If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE. To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

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.

E. 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. 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.

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

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ ____ / ____ / ____
[Signature] [Date]

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____

_____

_____

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (December 2004).

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VALUE ADDED PROGRAM

PATIENT ACKNOWLEDGEMENT & AGREEMENT

Patient Name: _____ *(please print)*

1. Program Provider. The Program is provided by Private Physicians Medical Associates ("PPMA"), a California partnership of professionals and/or professional corporations. Your PPMA physician can furnish the names of PPMA's health care providers. Currently these providers include James M. Weiss, M.D., and Lawrence Richard Van Meter, M.D.

2. Participation in Program. By signing this Patient Acknowledgement & Agreement ("Agreement"), you are requesting to participate in the Program. By countersigning this Agreement, PPMA is accepting you into the Program. (However, PPMA has no obligation to accept you into the Program.) *Either you or PPMA may terminate participation by sending the other written notice of termination. The notice must be received at least thirty (30) days before the termination is effective.*

3. Annual Program Fee.

   a. Annual Fee.
      - *COUPLE RATE* – Monthly Payments - $350/mo
        OR
      - *COUPLE RATE* – One Time Payment - $3990 *(5% discount)*

      - *INDIVIDUAL RATE* – Monthly Payments - $200/mo
        OR
      - *INDIVIDUAL RATE* – One Time Payment - $2280 *(5% discount)*

   Patient hereby agrees to pay PPMA the balance of payments shown above in

   - 12 equal monthly installments of $_____
   - One-time payment of $_____

   with the first installment to be received in PPMA's office no later than the 15th of every month until paid in full.

   Such payments will be made by:

   ❑ Check

   OR automatic payment through patient credit card which is hereby authorized

   ❑ Visa _____exp _____

   ❑ MasterCard _____exp _____

   ❑ AMEX _____ exp _____

   _____ _____

   [SIGNATURE OF PATIENT FOR CREDIT CARD AUTHORIZATION] [DATE]

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VALUE ADDED PROGRAM

PATIENT ACKNOWLEDGEMENT & AGREEMENT (continued)

PPMA may change the Annual Fee and/or the amount of it allocated to your Annual Physical. PPMA must notify you by mail before it makes changes, and any change will not become effective until your next anniversary date. PPMA will deposit any notice of change with the US Postal Service at least thirty (30) days before the effective date of change.

b. No Insurance. You should not expect your health care insurance (including Medicare) to cover or pay for any components of the Program. By signing this Agreement, *you are acknowledging that lack of insurance coverage for the Program.*

c. Corporate Refund. (1)General. If you stop participating in the Program, PPMA will return a prorated portion of the Annual Fee.

4. General Medical Care. PPMA will also provide your general medical and health care ("General Medical Care"), which is *not a part of the Program*. You agree to be financially responsible for paying all goods and services that PPMA provides as part of your General Medical Care. PPMA will charge its usual and customary rates for your General Medical Care (unless otherwise limited by law or contract). To the extent you have insurance, on your request for convenience; PPMA will prepare and submit bills to your insurer for your General Medical Care. The Annual Fee does not affect any co-payments, deductibles or co-insurance you might have.

5. Entire Agreement. This Agreement contains all of the terms of our agreement about this Program. There are no other promises or representations about the Program.

6. Miscellaneous. California law will control this Agreement and its interpretation.

PATIENT

_____ _____ / _____ / _____
[PATIENT'S SIGNATURE] [DATE]

_____
[PATIENT'S PRINTED NAME]

PRIVATE PHYSICIANS MEDICAL ASSOCIATES

By: _____ _____
[SIGNATURE] [DATE]

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Patient Care Information (Confidential)

Patient Name: _____

When it becomes necessary to contact you by phone, please list the number(s) where you wish us to call.
_____ OR _____

May we leave messages, such as lab results, appointments or other medical information on an answering device, or with another person who answers the phone, at that number? YES ( ) NO ( )

Please list any family members, physicians or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name: _____ Relationship to patient: _____
Phone: _____
Type of information: O All O Scheduling/Appointment O Medical O Billing/Insurance

Name: _____ Relationship to patient: _____
Phone: _____
Type of information: O All O Scheduling/Appointment O Medical O Billing/Insurance

Specific instructions or limitations:
_____

We will continue to rely on the information on this form when communication with family members or other involved in your care unless you request changes. Please promptly notify us if you wish to alter the designations above.

Email Disclosure:
Our email is not considered a confidential communication. As such, other may view privileged information.

Non-Synchronous Communication:
The nature of email communication is such that correspondence can be delayed. Additionally, technical limitations and errors can occur and delay reply. Because email is a non-synchronous means of communication, matter that are urgent in nature or require immediate response should never be transmitted via email.

By signing below, you are stating that you have read and understand the above information and approve of email as a method of communication with PPMA, its staff and physicians.

Patient Signature: _____ Date: _____

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