PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Patient Registration Information

HOW DID YOU HEAR ABOUT US? ☐ NEWSPAPER ☐ SOCIAL MEDIA/WEB SEARCH ☐ INSURANCE REFERRAL ☐ FAMILY/FRIEND

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐ M ☐ F
	N/A				

BILLING ADDRESS	CITY	STATE	ZIP

PHYSICAL ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL (example@test.com)

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

EMERGENCY CONTACT NAME	EMERGENCY PHONE XXX-XXX-XXXX

ADDRESS	PHONE#	OCCUPATION

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)
ADDRESS	ADDRESS
CITY, STATE, ZIP	CITY, STATE, ZIP

WORK PHONE	OCCUPATION	WORK PHONE	OCCUPATION

POLICY HOLDER/GUARANTOR (If different than patient)

NAME (Last, First, M.I.)	SSN	BIRTH DATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX: ☐M ☐F

BILLING ADDRESS	CITY	STATE	ZIP

STREET ADDRESS (If different than billing)	CITY	STATE	ZIP

HOME PHONE XXX-XXX-XXXX	WORK PHONE XXX-XXX-XXXX	CELL PHONE XXX-XXX-XXXX	EMAIL

PREFERRED CONTACT METHOD (Required) ☐Home ☐Work ☐Cell ☐Email ☐Text	MARITAL STATUS	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMT. PCP $	SPECIALIST
ADDRESS OF INSURANCE COMPANY		DEDUCTIBLE AMT. SELF	DEDUCTIBLE AMT. FAMILY
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY #	
NAME OF POLICY HOLDER	BIRTH DATE	GROUP #	
RELATIONSHIP TO PATIENT		COPAY AMTOUNT $	
ADDRESS OF INSURANCE COMPANY		DEDUCTIBLE AMTOUNT	
CITY, STATE, ZIP		EFFECTIVE DATE	EXPIRATION DATE

REFERRAL INFORMATION

NAME OF REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Arch Health Medical Group 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.

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.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Arch Health Medical Group.

Patient / Guardian Signature _____ Date _____ Relationship to Patient _____

Patient Financial Agreement

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

PATIENT INFORMATION

Deductible/Co-Insurance: All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. **Initials** _____

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived. **Initials** ____

Checks: Returned checks may be subject to a $30.00 fee. **Initials** ____

Cash Pay Patients: The amounts 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. **Initials** ____

Claims Submission: As a courtesy, Arch Health Medical Group will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. 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 and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency. **Initials** ____

Preventative Care Services: Routine exams may be covered by your insurance. When a medical concern is addressed at the time of your visit, preventative benefits will no longer apply. Additional fees may incur including but not limited to co-pays, deductibles and co-insurance. **Initials** ____

Ancillary Services: Laboratory and outpatient radiology procedures will be billed separately by an outside provider. Please contact them directly with any questions regarding your bill. **Initials** ____

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Arch Health Medical Group for all services rendered. **Initials** ____

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.

If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

I have read and understand the above statements. I**nitials** ____

I agree to comply with the financial policies of Arch Health Medical Group and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____

Patient / Guardian Signature Date

_____ _____

Patient Name (Please print) Date of Birth

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Authorization for Use or Disclosure of Health Information from Arch Health Medical Group to Designated Persons

Completion of this document authorizes the disclosure and use health information about you. Failure to provide all information requested may invalidate this authorization.

PATIENT INFORMATION	
*NAME (Last, First, M.I.)	MAIDEN OR OTHER NAME
*DATE OF BIRTH	PHONE

I, _____(patient) (please print) hereby authorize **Arch Health Medical Group** to release **any and all** information about my *health, medical condition* or *billing for services* to members of family or other persons, as specified below. This includes verbal discussions with the medical/nursing staff and copies of my medical record.

DESIGNATED PERSONS	
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE
NAME	PHONE

***THE PURPOSE OF THIS RELEASE IS**

☒ At my request ☐ Continuing medical care ☐ Other _____

Specify limitations (if any) on the use of the information: _____

Authorization for Use or Disclosure of Health Information from Arch Health Medical Group to Designated Persons

*Expiration of Authorization

This authorization becomes effective upon signing and will expire upon my written revocation.

Patient Rights

I, the patient or the patient's legal representative, understand that:

- I may revoke this authorization at any time in writing, signed by me or on my behalf and delivered or mailed to:

  Arch Health Medical Group
  15611 Pomerado Road
  Poway, CA 92064

If I revoke this authorization, the revocation will not have any effect on actions taken prior to Arch Health Partners receiving the revocation.

- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal privacy law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I have a right to a copy of this Authorization.

*
_____ _____
Patient / Guardian Signature Date

*
_____
If Legal Representative, State Relationship to Patient

***Required for valid Authorization**

Patient Diversity Form

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

PATIENT INFORMATION

Dear Arch Health Medical Group Patient:

The Federal Government requests the following questions be asked of every patient. Please select the preference that fits you the best and return this to the front office person. *** See below for race and ethnicity descriptons*

I identify my race as: (Please check one)

- ☐ I decline to self identify.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black, African American
- ☐ Native Hawaiian or other Pacific
- ☐ Islander Other Pacific Islander
- ☐ Other Race- _____
- ☐ White

I identify my ethnicity as: (Please check one)

- ☐ I decline to self identify.
- ☐ Central American
- ☐ Cuban
- ☐ Dominican
- ☐ Hispanic or Latino / Spanish
- ☐ Latin / American / Latin, Latino Mexican
- ☐ Not Hispanic / Latino
- ☐ Puerto Rican
- ☐ South American
- ☐ Spaniard

My Language Preference is: (Please check one)

- ☐ English
- ☐ Spanish
- ☐ Tagalog
- ☐ Russian
- ☐ Persian / Farsi
- ☐ Other (Please specify) _____

***Race is defined as a "person's self-identification with one or more social group".*

***Ethnicity is defined as a "person's self-identification based on nationality, language, culture and religion, geography or family's origin."*

Notice of *Privacy Practices*

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Arch Health Medical Group
15611 Pomerado Road
Poway, CA 92064
Arch Health Medical Group Privacy Officer
858-673-2419

Effective Date: February 22, 2016

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 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). Under an OHCA, your healthcare information may be shared for the purposes of treatment, payment, and/or 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 Health Information Exchange (HIE) -

We may share your health information electronically with other organizations where you receive health care. Sharing information electronically is a faster way to get your health information to the health care providers treating you. HIE participants are required to meet rules that protect the privacy and security of your health and personal information. You have the right to opt out of sharing your health information.

16 Secure Patient Portal -

We have established a web-based system, called a Patient Portal, which allows us to securely communicate and transfer health care information to you. With your written consent, you will receive a user ID and password to access the Patient Portal. If your user ID or password to your Patient Portal is obtained by another person, your medical information is subject to improper disclosure. Please notify us immediately if you feel your Patient Portal is being improperly accessed.

17 Organ or Tissue Donation.

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

18 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.

19 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.

20 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.

21 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.

22 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.

23 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.

24 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.

25 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. We will also post the current notice on our website, where it can be found in the menu under the Patients and Visitors tab.

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.

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
P 415.437.8310; 415.437.8311 TDD
F 415.437.8329
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.

Aviso Sobre Las Practicas *De Privacidad*

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Arch Health Medical Group
15611 Pomerado Road
Poway, CA 92064
Responsable de privacidad Arch Health Medical Group
858-673-2419

Fecha de aplicación: 22 de febrero de 2016

ESTE AVISO DESCRIBE CÓMO PUEDE UTILIZARSE Y DIVULGARSE INFORMACIÓN MÉDICA Y CÓMO USTED PUEDE TENER ACCESO A ESTA INFORMACIÓN. POR FAVOR REVÍSELO CON CUIDADO.

Entendemos la importancia de la privacidad y estamos comprometidos a mantener la confidencialidad de su información médica. Realizamos registros de la atención médica que proporcionamos y podemos recibir esta información de otros. Utilizamos estos registros para proporcionar cuidados médicos de calidad o permitir que otros proveedores de atención médica lo hagan; para obtener el pago por los servicios que se le han proporcionado, según lo permitido por su plan de salud; además de permitirnos cumplir con nuestras obligaciones profesionales y legales para manejar este consultorio médico de manera apropiada. Por ley, debemos mantener la privacidad de la información médica protegida y proporcionar a los individuos el aviso de nuestras responsabilidades legales y prácticas de privacidad con respecto a la información médica protegida. Este aviso describe cómo podemos utilizar y divulgar su información médica. También describe sus derechos y nuestras obligaciones legales con respecto a su información médica. Si usted tiene preguntas acerca de este aviso, por favor contacte a nuestro responsable de privacidad que aparece al inicio del presente.

A. Cómo este consultorio médico puede utilizar o divulgar su información médica
Este consultorio médico recolecta su información médica y la almacena en una tabla o en una computadora. Este es su expediente médico. El expediente médico es propiedad de este consultorio médico, pero la información que permanece en el expediente médico le pertenece a usted. La ley nos permite utilizar o divulgar su información médica para los siguientes propósitos:

1 Tratamiento.
Utilizamos información médica sobre usted para proporcionarle atención médica. Divulgamos información médica a nuestros empleados y a otros que están involucrados en proporcionarle la atención que necesita. Por ejemplo, podemos compartir su información médica con otros médicos u otros proveedores de atención médica que proporcionarán servicios que nosotros no ofrecemos. O podemos compartir esta información con un farmaceuta que la necesita para expenderle una prescripción o con un laboratorio que realice una prueba. También podemos divulgar su información médica a los miembros de su familia o a otros que puedan ayudarle cuando usted esté enfermo/a o lesionado/a.

2 Pagos.
Utilizamos y divulgamos información médica suya para obtener el pago por los servicios que le proporcionamos. Por ejemplo, le damos la información que necesita su plan de salud para que este nospague. También podemos divulgar información a otros proveedores de atención médica para ayudarles a obtener el pago por los servicios que le han proporcionado a usted.

3 Operaciones de atención médica.
Podemos utilizar y divulgar información médica suya para manejar este consultorio médico. Por ejemplo, podemos utilizar y divulgar esta información para revisar y mejorar la calidad de la atención que proporcionamos, o las competencias y certificaciones de nuestro personal profesional. O podemos utilizar y divulgar esta información para obtener su plan de salud para autorizar servicios o remisiones. También podemos utilizar y divulgar esta información, según sea necesario, para revisiones médicas, servicios legales y auditorías, incluso fraude, detección de abuso, cumplimiento de los programas y gestión y planificación del negocio. Además podemos compartir su información médica con nuestros "socios de negocios", como por ejemplo, nuestro servicio de facturación, que realiza los servicios administrativos para nosotros. Tenemos un contrato por escrito con cada uno de estos socios de negocios que contiene cláusulas que los obligan a proteger la confidencialidad y seguridad de su información médica. Aun cuando las leyes federales no protegen la información médica que se divulgue a otra persona que no sea un proveedor de atención médica, plan médico, centro de intercambio de información de asistencia médica o uno de nuestros socios de negocios, las leyes de California prohíben a todos los receptores de información médica continuar divulgándola excepto cuando la ley específicamente lo exija o lo permita. También podemos compartir su información con otros proveedores de atención médica, centros de intercambio de información de atención médica o planes de salud que tengan relación con usted, cuando ellos soliciten esta información para ayudarlos con su evaluación de calidad y actividades de mejoras, sus actividades de seguridad del paciente, sus esfuerzos basados en la población para mejorar la salud o reducir los costos de atención médica, desarrollo de protocolos, gestión de casos o actividades de coordinación de atención, su revisión de competencias, certificaciones, y desempeño de los profesionales de la atención médica, sus programas de capacitación, su acreditación, actividades de autorización o certificación, sus actividades relacionadas con los contratos de seguro médico o beneficios médicos, o sus esfuerzos para la detección de fraude y abusos de atención médica y para su cumplimiento. También podemos compartir información médica sobre usted con otros proveedores de atención médica, centros de intercambio de información de atención médica y planes de salud que participan con nosotros en los "Arreglos organizados de atención médica" (Organized Health Care Arrangements, OHCAs). Conforme con un OHCA, su información de atención médica puede ser compartida para propósitos de tratamiento, pago y/u operaciones de atención médica. En los OHCA participan hospitales, organizaciones médicas, planes de salud y otras entidades que proporcionan servicios de atención médica de forma colectiva. Un listado de los OHCA en los cuales participamos está a disposición en la oficina del responsable de privacidad.

4 Recordatorios de citas.
Podemos utilizar y divulgar información médica suya para contactarle y recordarle sus citas. Si no se encuentra en su casa, podemos dejarle esta información en su contestadora o en un mensaje con la persona que conteste el teléfono.

5 Registro de entrada.
Podemos utilizar y divulgar información médica suya al hacer que se registre cuando llegue a nuestra oficina. También podemos llamarlo por su nombre cuando estemos listos para atenderlo.

6 Notificación y comunicación a la familia.
Podemos divulgar su información médica para notificar o ayudar a notificar a un miembro de su familia, su representante personal u otra persona responsable de sus cuidados sobre su ubicación, su condición en general o, a menos que usted nos lo haya instruido de otra manera, en el caso de su muerte. En el caso de un desastre, podemos divulgar información a una organización de ayuda humanitaria de manera que ellos puedan coordinar estos esfuerzos de notificación. También podemos divulgar información a alguien que esté involucrado con sus cuidados o ayude a pagar sus cuidados. Si usted está en capacidad y disposición para aceptar u objetar estas divulgaciones, le daremos la oportunidad de objetar antes de hacerlas, aun cuando podemos divulgar esta información en el caso de un desastre aun por encima de su objeción si consideramos que es necesario para responder a las circunstancias de emergencia. Si no se encuentra en capacidad y con disposición para aceptar u objetar, nuestros profesionales de la salud utilizarán su mejor juicio para comunicarse con su familia y con otros.

7 Mercadeo.
Siempre que no recibamos ningún pago por realizar estas comunicaciones, podemos contactarle para alentarle a comprar o utilizar productos o servicios relacionados con su tratamiento, gestión de caso o coordinación de cuidados; o para dirigirlo o recomendarle otros tratamientos, terapias, proveedores de atención médica o entornos de cuidados que puedan interesarle. De manera similar, podemos describir productos o servicios proporcionados por este consultorio e informarle en cuales planes de salud participamos,

Podemos recibir compensación financiera por hablar con usted frente a frente, proporcionarle pequeños regalos promocionales o por cubrir nuestro costo por recordarle que tome y resurta su medicación, o de alguna otra manera, comunicarle sobre un fármaco o producto biológico prescrito a usted en la actualidad, pero solo si usted:

- (1) tiene una enfermedad crónica que lo debilita seriamente o que amenaza su vida y la comunicación se hace para educarle o asesorarle sobre las opciones del tratamiento y de alguna otra manera, mantener adherencia a un plan de tratamiento prescrito, o
- (2) usted está inscrito en un plan de salud en la actualidad y la comunicación se limita a la disponibilidad de medicamentos con mejor relación costo-efectividad.

Si realizamos estas comunicaciones mientras usted presenta una condición crónica que lo debilita seriamente o que amenaza su vida, proporcionaremos un aviso de lo siguiente en una letra de tamaño igual o mayor a 14 puntos:

- (1) el hecho y la fuente de la remuneración, y
- (2) su derecho a darse de baja de comunicaciones remuneradas futuras llamando al número gratuito del comunicador. No utilizaremos o divulgaremos de otra manera su información médica para propósitos de mercadeo ni aceptaremos ningún pago por otras comunicaciones de mercadeo sin su autorización previa por escrito. La autorización divulgará si nosotros recibimos alguna compensación financiera por alguna actividad de mercadeo que usted autorice y detendremos cualquier actividad de mercadeo futura en la medida en la que usted revoque dicha autorización.

8 Venta de la información médica.
No venderemos su información médica sin su autorización previa por escrito. La autorización divulgará que nosotros recibiremos alguna compensación por su información médica si usted nos autoriza a venderla y detendremos cualesquiera ventas futuras de su información en la medida en la que usted revoque dicha autorización.

9 Exigido por ley.
Como lo exige la ley, utilizaremos y divulgaremos su información médica, pero limitaremos nuestro uso y divulgación a los requerimientos relevantes de la ley. Cuando la ley nos exija que reportemos abuso, negligencia o violencia doméstica o que respondamos ante procedimientos judiciales o administrativos o ante agentes policiales, nosotros cumpliremos además con los requerimientos, relacionados con esas actividades, expuestos más adelante.

10 Salud pública.
Podemos, y algunas veces la ley nos exige, divulgar su información médica a las autoridades de salud pública para propósitos relacionados con: la prevención y control de enfermedades, lesiones o discapacidades; el reporte de abuso o negligencia de niños, personas de la tercera edad o adultos dependientes; el reporte de violencia doméstica; el reporte sobre problemas con productos y reacciones a medicamentos a la Administración de Alimentos y Medicamentos (Food and Drug Administration, FDA) y el reporte de exposición a enfermedades o infecciones. Cuando reportemos sospechas de abuso de personas de la tercera edad o de adultos dependientes o de violencia doméstica, le informaremos con prontitud a usted o a su representante personal, a menos que a nuestro mejor juicio profesional, consideremos que la notificación lo colocaría en riesgo de gran peligro o requeriría informar al representante personal que nosotros creemos es el responsable del abuso o daño.

11 Actividades de supervisión la salud.
Podemos, y algunas veces la ley nos exige, divulgar su información médica a los organismos de supervisión de la salud durante el desarrollo de auditorías, investigaciones, inspecciones, acreditaciones y otros procedimientos, sujetos a las limitaciones impuestas por las leyes federales y las de California.

12 Procedimientos judiciales y administrativos.
Podemos, y algunas veces la ley nos exige, divulgar su información médica en el desarrollo de cualquier procedimiento administrativo o judicial en la medida expresamente autorizada por un tribunal o una orden administrativa. También podemos divulgar información sobre usted en respuesta a una citación, una solicitud de descubrimiento u otro proceso legal si se han realizado esfuerzos razonables para notificarle de la solicitud y usted no ha objetado o si sus objeciones se han resuelto a través de un tribunal o una orden administrativa.

13 Agentes policiales.
Podemos, y algunas veces la ley nos exige, divulgar su información médica a un agente policial para propósitos como por ejemplo, la identificación de la ubicación de un sospechoso, fugitivo, testigo material o persona desaparecida, cumpliendo con una orden del tribunal, una orden judicial, una citación del gran jurado u otros propósitos policiales.

14 Jueces de instrucción.
Podemos, y algunas veces la ley nos exige, divulgar su información médica a los jueces de instrucción en relación con sus investigaciones de muertes.

15 Intercambio de Información de la Salud (Health Information Exchange, HIE):

Podemos compartir su información médica de manera electrónica con otras organizaciones en donde reciba atención médica. Compartir información de manera electrónica es una manera más rápida de proporcionar su información médica a sus proveedores de atención médica que lo estén tratando. Se exige a los participantes del HIE cumplir con las reglas que protegen la privacidad y seguridad de la salud y de la información personal. Usted tiene derecho a darse de baja y no compartir su información médica.

16 Portal del paciente seguro:

hemos establecido un sistema basado en la web, denominado Portal del Paciente, el cual nos permite comunicarle y transmitirle información médica de manera segura. Con su consentimiento por escrito, recibirá una identificación de usuario y una contraseña para acceder al Portal del Paciente. Si su identificación de usuario o contraseña del Portal del Paciente la obtiene otra persona, su información médica está sujeta a divulgación inapropiada. Por favor, notifíquenos de inmediato si usted siente que han accedido a su Portal del Paciente de manera inapropiada.

17 Donación de órganos o tejidos.

Podemos divulgar su información médica a organizaciones que esté involucradas en conseguir, almacenar o trasplantar órganos y tejidos.

18 Seguridad pública.

Podemos, y algunas veces la ley nos exige, divulgar su información médica a las personas adecuadas para prevenir o disminuir una amenaza inminente y seria a la salud o seguridad de una persona determinada o del público en general.

19 Prueba de inmunización.

Divulgaremos prueba de inmunización a una escuela en donde la ley exija que la escuela tenga dicha información antes de admitir a un estudiante si usted acepta la divulgación en su nombre propio o en el de su dependiente.

20 Funciones gubernamentales especializadas.

Podemos divulgar su información médica para propósitos militares o de seguridad nacional o a las instituciones correccionales u agentes policiales que lo mantengan a usted en custodia legal.

21 Compensación de los trabajadores.

Podemos divulgar su información médica según sea necesario para cumplir con las leyes de compensación de los trabajadores. Por ejemplo, en la medida en que sus cuidados sean cubiertos por la compensación de trabajadores, haremos informes periódicos a su empleador sobre su condición. También se nos exige por ley reportar los casos de lesiones o enfermedades ocupacionales al empleador o a la compañía aseguradora de la compensación del trabajador.

22 Cambio de propietario.

En el caso que este consultorio médico fuera vendido o se fusionara con otra organización, su información/expediente médico será propiedad del nuevo propietario, aun cuando usted mantendrá el derecho de solicitar que las copias de su información médica sean transferidas a otro médico o grupo médico.

23 Notificación de violación a la seguridad.

En el caso de una violación de la información de salud protegida no asegurada, le informaremos como exige la ley. Si nos ha proporcionado una dirección de correo electrónico actual, podemos utilizar ese correo para comunicarle la información relacionada con esa violación. En algunas circunstancias, nuestro socio de negocios podría proporcionarle la notificación. También podemos notificarle por otros medios, según proceda.

24 Investigación.

Podemos divulgar su información médica a investigadores que estén llevando a cabo alguna investigación con respecto a la cual no se requiera su autorización por escrito, según sea aprobado por una Junta de Revisión Institucional o una junta privada, en cumplimiento con la legislación aplicable.

25 Recaudación de fondos.

Podemos utilizar o divulgar su información demográfica, las fechas en las cuales usted recibió tratamiento, el departamento de servicio, su médico tratante, información de resultados y estado del seguro médico de manera de contactarle para nuestras actividades de recaudación de fondos. Si no desea recibir estos materiales, infórmelo al responsable de privacidad que aparece al principio de este Aviso de Prácticas de Privacidad y detendremos cualesquiera comunicaciones de recaudación de fondos futuras. De manera similar, usted debería notificar a la oficina de privacidad si decide que desea comenzar a recibir estas solicitudes de nuevo.

B. Cuándo no puede este consultorio médico utilizar o divulgar su información médica

Exceptuando como se indica en este Aviso de Prácticas de Privacidad, este consultorio médico, consistente con sus obligaciones legales, no utilizará ni divulgará información médica que lo identifique a usted sin su autorización por escrito. Si usted autoriza a este consultorio médico a utilizar o divulgar su información médica para otro propósito, puede revocar su autorización por escrito en cualquier momento.

C. Sus derechos de información médica

1 Derecho a solicitar protecciones de privacidad especial.

Tiene derecho a solicitar restricciones en ciertos usos y divulgaciones de su información médica mediante una solicitud por escrito en la cual especifique qué información desea limitar y cuáles limitaciones desea imponer a nuestro uso o divulgación de dicha información. Si nos indica que no divulguemos información a su plan de salud comercial relacionado con artículos o servicios de atención médica que usted pagó completamente de su bolsillo, nosotros cumpliremos con su solicitud, a menos que debamos divulgar la información por razones legales o de tratamiento. Nos reservamos el derecho a aceptar o rechazar cualquier otra solicitud y le notificaremos nuestra decisión.

2 Derecho a solicitar comunicaciones confidenciales.

Tiene derecho a solicitar recibir su información médica en una manera determinada o en un lugar específico. Por ejemplo, puede pedir que le enviemos información a una cuenta de correo electrónico determinada o a su dirección de trabajo. Cumpliremos con todas las solicitudes razonables enviadas por escrito en las cuales se especifique cómo y dónde desea recibir estas comunicaciones.

3 Derecho a consultar y copiar.

Tiene derecho a consultar y copiar su información médica, con excepciones limitadas. Para acceder a su información médica, debe enviar una solicitud por escrito detallando a qué información desea acceder, si desea consultarla u obtener una copia. En el caso que desee una copia, la forma y formato de su preferencia. Proporcionaremos copias en el formato y forma solicitada si es fácil de preparar; o le proporcionaremos un formato alternativo que usted encuentre aceptable, o si no podemos estar de acuerdo y mantenemos el expediente de un formato electrónico, tiene la opción de un formato electrónico que se puede leer o un formato impreso. También enviaremos una copia a otra persona que usted designe por escrito. Le cobraremos un monto razonable que cubra nuestros costos de trabajo, materiales, gastos de envío; y si se solicita y acepta por adelantado, el costo de preparar una explicación o resumen, de acuerdo con las leyes federales y las de California. Podemos negar su solicitud bajo circunstancias limitadas. Si le negamos su solicitud a acceder al expediente de su hijo o de un adulto incapacitado que usted representa, porque creemos que permitir el acceso será razonablemente probable que cause daño sustancial al paciente, usted tendrá derecho a apelar nuestra decisión. Si negamos su solicitud a acceder a las anotaciones de su psicoterapia, tendrá derecho de transferirlas a otro profesional de la salud mental.

4 Derecho a enmendar o complementar.

Tiene derecho a solicitar que enmendemos su información médica que considere que no es correcta o que está incompleta. Debe hacer una solicitud para enmendar por escrito e incluir las razones por las cuales usted considera que la información no es exacta o está incompleta. No tenemos la obligación de cambiar su información médica y le proporcionaremos información sobre la negación de este consultorio médico y cómo puede usted estar en desacuerdo con esta negativa. Podemos negar su solicitud si no tenemos la información, si no creamos la información (a menos que la persona o entidad que creó la información ya no esté disponible para hacer la enmienda), si no se le permitió consultar o copiar la información en el momento de su publicación o si la información es exacta y completa tal como está. Si negamos su solicitud, puede enviar una declaración por escrito de su desacuerdo con esa decisión y podemos, a su vez, preparar una refutación por escrito. También tiene derecho a solicitar que agreguemos a su expediente una declaración no mayor a 250 palabras, que diga todo lo que usted cree que está incompleto o incorrecto en su expediente. Toda la información relacionada con cualquier solicitud de enmienda o complemento será mantenida y divulgada en conjunto con cualquier divulgación subsecuente de la información disputada.

5 Derecho a una contabilidad de divulgaciones.

Usted tiene derecho a recibir una contabilidad de divulgaciones de su información médica realizadas por este consultorio médico, excepto que esta práctica médica no posee una cuenta para las divulgaciones que se le han proporcionado a usted o conforme a su autorización por escrito, o como se describen en los párrafos 1 (tratamiento), 2 (pago), 3 (operaciones de atención médica), 6 (notificación y comunicación a la familia) y 18 (Funciones gubernamentales especializadas) de la sección A de este Aviso de Prácticas de Privacidad o divulgaciones para propósitos de investigación o salud pública que excluye identificadores directos del paciente o que son incidentes de uso o divulgación de otra manera permitida o autorizada por ley, o la divulgación a una agencia de supervisión de salud o un agente policial en la medida en que este consultorio médico haya recibido aviso de dicha agencia o agente de que proporcionar esta contabilidad sería razonablemente probable que impida sus actividades.

6 Tiene derecho a conocer nuestras responsabilidades legales y prácticas de privacidad con respecto a su información médica, incluso el derecho a una copia en papel de este Aviso de Prácticas de Privacidad, aun si la ha solicitado previamente recibirla por correo.

Si le gustaría tener una explicación más detallada de estos derechos o si le gustaría ejercer uno o más de estos derechos, contacte a nuestro responsable de privacidad que aparece al inicio de este Aviso de Prácticas de Privacidad.

D. Cambios a este Aviso de Prácticas de Privacidad

Nos reservamos el derecho a enmendar nuestras prácticas de privacidad y los términos de este Aviso de Prácticas de Privacidad en cualquier momento en el futuro. Hasta que se haga dicha enmienda, estamos obligados por ley a cumplir con este Aviso.

Una vez hecha una enmienda, el Aviso de Protecciones de Privacidad revisado aplicará a toda la información médica protegida que mantenemos, independientemente de cuando se haya creado o recibido. Mantendremos una copia del aviso actual colocado en el área de la recepción y una copia estará disponible en cada cita. También publicaremos el aviso actual en nuestra página web, donde podrá encontrarlo en el menú en la pestaña de Pacientes y Visitantes.

E. Quejas.

Las quejas sobre este Aviso de Prácticas de Privacidad o cómo este consultorio médico maneja su información médica deberán ser dirigidas a nuestro responsable de privacidad que aparece en la parte superior del presente.

Si usted no está satisfecho con la manera en la que esta oficina maneja una queja, puede enviar una queja formal a:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
P 415.437.8310; 415.437.8311 TDD
F 415.437.8329
OCRMail@hhs.gov

Puede encontrar el formulario de quejas en:
www.hhs.gov/ocr/privacy/hipaa/complaints/ hipcomplaint.pdf.
No será penalizado de ninguna manera si presenta una queja.

Notice Of Privacy Practices

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Patient Label Here

Patient Name: _____

DOB: _____ MRN: _____

Acknowledgement of Receipt

PATIENT INFORMATION

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Patient / Guardian Signature Date

_____ _____
Patient Phone XXX-XXX-XXXX Name of Physician

By signing this form, the patient acknowledges receipt of the "Notice of Privacy Practices" of Arch Health Medical Group. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information. We encourage you to read it in full.

I acknowledge receipt of the "Notice of Privacy Practices" of Arch Health Medical Group.

_____ _____
Patient / Guardian Signature Date

_____
If legal representative, state relationship to patient

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

My email address is: _____

AHMG Advance Directive Information

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Patient Label Here

Patient Name: _____

DOB: _____ MRN: _____

Your Rights as an Arch Health Medical Group Patient

You have a legal right to make known your wishes about your medical care, including the right to accept or refuse treatment. The document "Advance Health Care Directive" is a means to specify your wishes and to make them legally binding.

What is an Advance Health Care Directive?

This is a legal document that enables you to specify your desires about life-sustaining treatment. It also allows you to name someone you trust to speak for you when you are incapacitated. This document replaces "Living Wills" and the "Durable Power of Attorney for Health Care". You can identify your primary care physician and specify your wishes about CPR, feeding tubes, breathing machines, pain medication, organ donation and other desires.

How do I find out more?

- **Internet Resources**
  http://ag.ca.gov/consumers/general/adv_hc_dir.php
  http://www.cmanet.org/about/patient-resources/end-of-life-issues/advance-directives
  http://www.coalitionccc.org/
- **The booklet "Finding Your Way"** is a useful guide to thinking about and discussing these issues. To order a copy, send $1.50 check (payable to "CHCD") to Center for Healthcare Decisions, 3400 Data Drive, Rancho Cordova, CA 95670 or order it through their website, **www.chcd.org**.

How do I obtain an Advance Healthcare Directive form?

The California Medical Association – Kit available for nominal fee (currently $6)

1201 J St. STE 200
Sacramento, CA 95814

Phone: **800.786.4262**
Fax: **916.551.2036**

Obtain the form on-line free of charge at:
http://ag.ca.gov/consumers/pdf/AHCDS1.pdf

What other kinds of directives are available?

- Physician Orders for Life-Sustaining Treatment (POLST) – this complements the Advance Directive by having a physician order signed and ready-to-go in the event you need life-sustaining treatment. Specific instructions may be made about CPR and medical interventions like assisted breathing and artificial feeding.

Arch Health Medical Group has a written policy on Advance Directives. Check the box below if you wish more information.

Patients: Please check the appropriate box(es):

☐ I have an Advance Directive and/or POLST. I will provide Arch Health Medical Group with a copy. [Give the copy to one of our staff or mail to AHMG, 15611 Pomerado Road, Poway, CA 92064, ATTN: Medical Records.]

☐ I have an Advance Directive/POLST but do not wish to provide AHMG with a copy.

☐ I do not have an Advance Directive/POLST.

☐ I would like more information on Arch Health Medical Group policy on Advance Directives.

_____ _____

Signature of Patient or Patient's Legal Representative Date

Patient Name: _____
DOB: _____
Date: _____

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Reason for Visit

Orthopedic treatment is often a result of an accident or injury, your insurance company may require the details of your visit before processing your claim(s) for payment; this information is often used to determine financial liability. Most insurance companies will not pay claims without this information.

NAME (PLEASE PRINT):_____DOB: _____

If you are here for a reason OTHER THAN AN ACCIDENT, please complete this section

My visit is due to_____Date first noticed: _____

Place occurred (home, work, school, etc) _____

Please describe how this may have occurred: _____

_____

_____

If you are here DUE TO AN ACCIDENT; please complete this section

My visit is due to an accident: No ☐ Yes ☐ If yes, date of accident: _____

Location of accident (home, work, school, care, etc) _____

Please describe how the accident occurred: _____

_____

_____

Name of Medical Insurance Company: _____

Is there any other insurance company or entity that may be financially responsible for payment of this claim, such as an automobile insurance, homeowners insurance, student insurance, etc.? If so, please explain and provide any additional information so we can determine who the appropriate entity is to be billed for your services.

Note: Although you may advise us that another entity is responsible for payment of the claims, *our office does not file third party billing*; and if it is determined that a third party is responsible, we will provide you with the necessary paperwork to submit your claims. In the meantime, you are financially responsible for any outstanding bills due Arch Health Partners Orthopedic Surgery Associates and payment will be expected upon receipt of the first itemized statement.

My signature below indicates that I have read the above and understand I am financially responsible for all medical care rendered, pending any liability disputes.

Signature:_____**Date**: _____

Patient Name: _____
DOB: _____
Date: _____

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Patient Health Questionnaire

Describe your symptoms including how and when they began.

_____

_____

Is this a work related injury: Yes/ No_____

If yes, what is the last date you worked? _____

How often do you experience your symptoms?
☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

Describe where your pain is located:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How would you describe your symptoms?
☐ Sharp ☐ Dull ache ☐ Burning
☐ Numb ☐ Tingling ☐ Stiffness

Other (please describe)_____

Since they began, have your symptoms changed?
☐ Improving ☐ Not Changing ☐ Worsening

Since they began, indicate the average intensity of your symptoms (Please check one)

0 1 3 4 5 6 7 8 9 10

Hand Dominance?
☐ Right ☐ Left

How much has your pain interfered with your normal work (Including work outside the home, and housework)?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Since it started, how much has your condition interfered with social activities?
☐ All the time ☐ Most of the time ☐ Some of the time ☐ Very little ☐ None

Have you seen a medical professional for your symptoms? If so, who? _____

a. What treatment did you receive and when? _____
b. What tests have you had for your symptoms? If so, when and where were they performed?
☐ X-rays ☐ MRI ☐ CT Scan ☐ Neurology (i.e. EMG, Nerve study) ☐ Other

What, if anything, alleviates the symptoms of your condition?(i.e.Rest, ice, elevation, bracing, injection, NSAID,PT)

Patient Name: _____
DOB: _____
Date: _____

PALOMAR HEALTH MEDICAL GROUP
Reimagining Healthcare™

Your Medical History:

Surgical History: *Please list all previous procedures starting with the most recent*

Past Operations | Year | Anesthesia (general, spinal) | Complications

_____

_____

_____

Weight: _____ Height: _____

Yes	No		Yes	No		Yes	No	
☐	☐	Heart disease	☐	☐	Emphysema	☐	☐	Frequent headaches
☐	☐	Angina, chest pain	☐	☐	Asthma or wheezing	☐	☐	Drug/alcohol addiction
☐	☐	Irregular heart beat	☐	☐	Diabetes	☐	☐	Epilepsy/Stroke
☐	☐	High blood pressure	☐	☐	Heart "attack"	☐	☐	Mental Illness
☐	☐	Bleeding tendency	☐	☐	Hiatal hernia/ulcer	☐	☐	Hepatitis,Jaundice,Liver Disease
☐	☐	Cancer	☐	☐	Sickle cell disease	☐	☐	Sleep Apnea
☐	☐	Lung diseases	☐	☐	Glaucoma	☐	☐	Other illness(s)

	Yes	No	
Do you or have you smoked?	☐	☐	If yes, have you quit? _____
Do you drink alcohol?	☐	☐	If yes, how much? _____
Do you consume caffeine?	☐	☐	(i.e, coffee, tea, chocolate)
Females – Could you be pregnant?	☐	☐	

Please list any medications (including OTC) you are taking or have taken in the last six months:

_____

_____

Please list any allergies to medications or tape:

_____

_____

Immediate Family Medical History:

Yes	No		Yes	No		Yes	No	
☐	☐	Orthopedic Surgery (Non-trauma)	☐	☐	Diabetes	☐	☐	Epilepsy/Stroke
☐	☐	Drug/alcohol addiction	☐	☐	High blood pressure	☐	☐	Mental Illness
☐	☐	Bleeding tendency	☐	☐	Sickle cell disease	☐	☐	Other illness(s)

If yes, what is their relationship to you?_____

Please list the name of your pharmacy and, if possible, the phone number and address:

_____

What is your occupation? _____

Patient Name: _____
DOB: _____
Date: _____

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems
Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems
Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems
Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems
Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems
Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems
Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems
Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other:_____

Integ. (Skin, Hair & Breast) ❑ No Problems
Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems
Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems
Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems
Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems
Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems
Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Patient Name: _____

DOB: _____

MRN:_____

Patient Health Questionnaire – PHQ

If you are being seen for your HIP or KNEE, please complete this section

1. Function

a.Limp

- ☐ None
- ☐ Slight
- ☐ Moderate
- ☐ Severe
- ☐ Unable to walk

b. Distance Walked

- ☐ Unlimited
- ☐ 6 Blocks
- ☐ 2-3 blocks
- ☐ Indoors Only
- ☐ Bed to Chair

c. Stairs

- ☐ Normal
- ☐ Handrail Needed
- ☐ No Stairs

d. Sitting

- ☐ As long as needed
- ☐ Limited
- ☐ Uncomfortable

e. Socks/Shoes

Left	Right
☐ With Ease	☐ With Ease
☐ With Difficulty	☐ With Difficulty
☐ Unable	☐ Unable

f. Toenail Clipping

Left	Right
☐ With Ease	☐ With Ease
☐ With Difficulty	☐ With Difficulty
☐ Unable	☐ Unable

2. Do you have night pain	☐ Yes	☐ No
3. Do you have pain while resting	☐ Yes	☐ No
4. Do you have pain on arising from sitting	☐ Yes	☐ No
5. Is your pain worsened by:		
a. Going Upstairs	☐ Yes	☐ No
b. Going Downstairs	☐ Yes	☐ No

KNEE ONLY

6. Does your knee give out or buckle?	☐ Yes	☐ No
7. Does your knee “catch” or “lock up” ?	☐ Yes	☐ No
8. Can you squat?	☐ Yes	☐ No