

CANCER CENTER ONCOLOGY MEDICAL GROUP

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Dear New Patient:

Welcome. Please find enclosed paperwork that will be needed for your first visit to our facility.

To reduce your waiting time in our office, please take a few minutes to complete the enclosed forms before your arrival.

Also, please be sure to bring the following information with you to our office when you arrive for your appointment:

1. Completed initial paperwork.
2. All pertinent insurance cards, including your prescription card and current identification.
3. All medications that you are currently taking, including over-the-counter medications and vitamins and supplements.
4. Please arrive 30 minutes before your scheduled appointment time.

If you have any question please feel free to contact our office at 619-644-3030 ext. 132. Thank you for taking the time to complete this very important paperwork. Our entire staff looks forward to meeting you.

Sincerely,

Cancer Center Oncology Medical Group


THE DAVID &   DONNA LONG
CENTER FOR CANCER TREATMENT

5555 Grossmont Center Drive • La Mesa, California 91942 • (619) 644-3030 • Fax (619) 644-3638

**CANCER CENTER ONCOLOGY MEDICAL GROUP
REGISTRATION FORM**

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital status (circle one) Single / Mar / Div / Sep / Wid / Other			
Social Security #:	Birth Place: City,State,Country		Birth date: / /
		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Ethnicity/Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Pacific Islander/Native Hawaiian			
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Patient Declined			
Street address:		Home phone no.: ()	Cell phone no.: ()
P.O. box:	City:	State:	ZIP Code:
Spouse/Parent Name:		Spouse/Parent Phone Number: ()	
Occupation:	Employer:	Employer phone no.: ()	
May we contact you at work: <input type="checkbox"/> Yes <input type="checkbox"/> No		Email:	
How did you hear about our clinic (please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital			
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Community Event <input type="checkbox"/> Website <input type="checkbox"/> Internet <input type="checkbox"/> Other			
Other family members seen here:			
May we give any medical information/results: to your spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No on your answering machine: <input type="checkbox"/> Yes <input type="checkbox"/> No			

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ()
Occupation:	Employer:	Employer address:	Employer phone no.: ()
Name of primary insurance:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:
		Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Name of secondary insurance:			
Subscriber's name:	Subscriber's S.S. no.:	Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CANCER CENTER ONCOLOGY MEDICAL GROUP or insurance company to release any information required to process my claims.			
_____ Patient/Guardian signature		_____ Date	

CANCER CENTER ONCOLOGY MEDICAL GROUP
5555 GROSSMONT CENTER DRIVE, LA MESA, CA 91942
Phone: 619-644-3030 Fax: 619-644-3638

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ AGE: _____ DATE _____

SURGERIES (include skin, eye, orthopedic, etc.):

Type of surgery	Month/Year	Type of surgery	Month/Year
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

MEDICAL HISTORY (i.e. ulcers, stroke, high blood pressure, arthritis, thyroid, cholesterol, etc.):

Please list the medical problem that prompted you to see the doctor.

Type of problem	Approx. Date of Onset	Type of problem	Approx. Date of Onset
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Last Menstrual Period _____ Number of Pregnancies _____

FAMILY HISTORY (Cancer, diabetes, dementia, coronary disease, osteoporosis, other):

<u>DECEASED OR LIVING</u>	<u>AGE (CURRENT OR AT DEATH)</u>	<u>DIAGNOSIS OR CAUSE OF DEATH</u>
<u>FATHER</u>	_____	_____
<u>MOTHER</u>	_____	_____
<u>SIBLING</u>	_____	_____
<u>SIBLING</u>	_____	_____
<u># OF SONS</u>	<u>ILLNESSES</u>	_____
<u># OF DAUGHTERS</u>	<u>ILLNESSES</u>	_____

HABITS:

DID YOU OR DO YOU USE TOBACCO? YES _____ NO _____ IF YES, AMOUNT? _____

DID YOU OR DO YOU USE ALCOHOL? YES _____ NO _____ IF YES, AMOUNT? _____

HAVE YOU EVER BEEN TREATED FOR DRUG ADDICTION? YES _____ NO _____ IF YES, WHEN? _____

HOW MANY CUPS OF COFFEE OR OTHER CAFFEINATED BEVERAGES DO YOU DRINK PER DAY? _____

CALCIUM INTAKE: SUPPLEMENTS/DAIRY PRODUCTS (AMOUNT, TYPE FREQUENCY) _____

EXERCISE: TYPE _____ DURATION _____ FREQUENCY _____

**CANCER CENTER ONCOLOGY MEDICAL GROUP
5555 GROSSMONT CENTER DRIVE
LA MESA, CA 91942
619-644-3030 FAX 619-644-3638**

REVIEW OF SYMPTOMS

<p><u>GENERAL</u></p> <p><input type="checkbox"/> WEIGHT LOSS</p> <p><input type="checkbox"/> FATIGUE</p> <p><input type="checkbox"/> LOSS OF APPETITE</p> <p><input type="checkbox"/> NIGHT SWEATS</p> <p><input type="checkbox"/> FEVER</p> <p><input type="checkbox"/> CHILLS</p> <p><u>EYES</u></p> <p><input type="checkbox"/> BLURRED VISION</p> <p><input type="checkbox"/> DOUBLE VISION</p> <p><input type="checkbox"/> DIFFICULTY SEEING</p> <p><u>EARS, NOSE, THROAT</u></p> <p><input type="checkbox"/> HEARING LOSS</p> <p><input type="checkbox"/> RINGING IN EARS</p> <p><input type="checkbox"/> SINUS TROUBLE</p> <p><input type="checkbox"/> DIFFICULTY SWALLOWING</p> <p><input type="checkbox"/> SORE THROAT</p> <p><input type="checkbox"/> NASAL DRAINAGE</p> <p><input type="checkbox"/> NOSE BLEEDS</p> <p><input type="checkbox"/> HOARSENESS</p> <p><u>CARDIAC</u></p> <p><input type="checkbox"/> CHEST PAINS</p> <p><input type="checkbox"/> HEART PALPITATIONS</p> <p><input type="checkbox"/> LIGHT HEADEDNESS</p> <p><input type="checkbox"/> SWELLING OF LEGS</p> <p><input type="checkbox"/> EPISODES OF PASSING OUT</p> <p><u>RESPIRATORY</u></p> <p><input type="checkbox"/> COUGH</p> <p><input type="checkbox"/> SPUTUM PRODUCTION</p> <p><input type="checkbox"/> COUGHING UP BLOOD</p> <p><input type="checkbox"/> SHORTNESS OF BREATH</p> <p><input type="checkbox"/> SLEEP APNEA</p> <p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> NAUSEA</p> <p><input type="checkbox"/> VOMITING</p> <p><input type="checkbox"/> HEARTBURN</p> <p><input type="checkbox"/> CONSTIPATION</p> <p><input type="checkbox"/> DIARRHEA</p> <p><input type="checkbox"/> ABDOMINAL PAIN</p> <p><input type="checkbox"/> RECTAL BLEEDING</p> <p><input type="checkbox"/> BOWEL INCONTINENCE</p>	<p><u>GENITO-URINARY</u></p> <p><input type="checkbox"/> VAGINAL BLEEDING</p> <p><input type="checkbox"/> BURNING ON URINATION</p> <p><input type="checkbox"/> PAIN WITH URINATION</p> <p><input type="checkbox"/> BLOOD IN URINE</p> <p><input type="checkbox"/> FREQUENT URINATION</p> <p><input type="checkbox"/> URINARY INCONTINENCE</p> <p><u>MUSCULO-SKELETAL</u></p> <p><input type="checkbox"/> MUSCLE PAIN</p> <p><input type="checkbox"/> STIFFNESS</p> <p><input type="checkbox"/> JOINT PAIN</p> <p><input type="checkbox"/> JOINT SWELLING</p> <p><input type="checkbox"/> BACK PAIN</p> <p><u>SKIN</u></p> <p><input type="checkbox"/> RASH</p> <p><input type="checkbox"/> OTHER SKIN COMPLAINTS</p> <p><u>NEUROLOGICAL</u></p> <p><input type="checkbox"/> HEADACHES</p> <p><input type="checkbox"/> SEIZURES</p> <p><input type="checkbox"/> DIZZINESS</p> <p><input type="checkbox"/> LOSS OF BALANCE</p> <p><input type="checkbox"/> WEAKNESS IN LIMBS</p> <p><input type="checkbox"/> LOSS OF SENSATION</p> <p><input type="checkbox"/> TINGLING SENSATION</p> <p><input type="checkbox"/> MEMORY LOSS</p> <p><input type="checkbox"/> DIFFICULTY THINKING</p> <p><u>PSYCHIATRIC</u></p> <p><input type="checkbox"/> NERVOUSNESS</p> <p><input type="checkbox"/> DEPRESSION</p> <p><input type="checkbox"/> RESTLESSNESS</p> <p><input type="checkbox"/> DIFFICULTY SLEEPING</p> <p><u>HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC</u></p> <p><input type="checkbox"/> BRUISING</p> <p><input type="checkbox"/> BLEEDING</p> <p><input type="checkbox"/> LUMPS IN ARMPITS</p> <p><input type="checkbox"/> LUMPS IN NECK</p> <p><input type="checkbox"/> LUMPS IN GROIN</p>
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PLEASE INDICATE IF YOU HAVE ANY ADDITIONAL PROBLEMS:

Medication	Dose	Number of Times Taken Per Day	Date Started	Prescribed By

OTHER MEDICATION I TAKE:

Remember to include on your list any over the counter (OTC) medicine you take (vitamins, herbs, pain relievers, supplements, etc.).

Other Medication	Dose	Number of Times Taken Per Day	Date Started

***Please note if you are unable to complete this form, please bring your medications with you in the original bottles.**

Cancer Center Oncology Medical Group
5555 Grossmont Center Drive
La Mesa, CA 91942
Tel (619)644-3030 Fax (619) 644-3638

CONSENT TO PROCEDURES

The undersigned consents to the services provided by Cancer Center Oncology Medical Group. The undersigned acknowledges that these services have been adequately explained, and all questions have been answered.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be provided to the patient, he/she is obligated to pay the charges. We bill patients' insurance as a courtesy, however, it is the patients' ultimate responsibility for payment for services provided.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment of the insurance benefits to which I may be entitled directly to Cancer Center Oncology Medical Group. Requested information may be released to the Insurance carrier.

NOTICE TO MANAGED CARE PATIENTS

Managed care Insurances generally require that a representative, often a Primary Care Physician, authorize services and diagnostic procedures before the plan will accept financial responsibility. Your signature below indicates that you agree to be responsible for payment if you receive services that are not authorized as required by your plan.

NOTICE TO MEDICARE PATIENTS

Medicare Authorization (for signature on file): I authorize the release of any medical information necessary to process claims. I also request payment of government benefits to the party who accepts assignment.

Patient Name (Print) _____

Patient Signature _____ Date: _____

Or

Designated agent's signature: _____ Date: _____

Relationship to patient: _____

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STATEMENT OF FINANCIAL POLICY

Dear Patient:

Thank you for choosing Cancer Center Oncology Medical Group as your provider. We are committed to providing you with quality health care. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). If you have questions, please let us know. Our billing office can be reached at (619) 644-3030 ext. 124 from 8:30am to 5:00pm.

1. **Insurance:** Your insurance policy is an agreement between you and your insurance company, we are not a party to your contract. As a courtesy, we will bill your insurance plan for you, as long as you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage.
 - a. **Non-contracted insurances:** if we are not contracted with your insurance company, Please be advised that your out-of-pocket costs may be greater than originally anticipated. We will give you an estimate of your costs, but the final amount due will be determined by reimbursement from your insurance company.
2. **Non-covered services:** Please be aware that some of the services you receive may not be covered or may not be considered reasonable or necessary by Medicare or other insurances. If this is the case we will inform you and require you to sign an ABN form. You will be responsible for any charges.
3. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that charges for services received are your responsibility whether or not your insurance company pays your claim.
4. **Proof of insurance:** All patients must complete a patient information form before seeing the physician. We will ask for a copy of your current insurance card(s) as proof of insurance and valid identification.
5. **Coverage change:** If your insurance changes, please notify our office immediately. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.
6. **Co-Payments:** All co-payments must be paid at the time of service.
7. **Non-Payment:** Please be aware that if you fail to pay your portion of your bill, we may refer your account to a collection agency and you may be discharged from this practice.
8. **Payment:** For your convenience, we accept cash, checks and credit cards. We accept Visa, MasterCard and Discover.
9. **Financial Counselor:** We have a Financial Counselor available as a resource to our patients. Please call (619)644-3030 ext. 127 if you need assistance.

I have read and understand the payment policy and agree to abide by these guidelines. I understand that I am responsible for any portion of my bill that is not covered by my insurance company.

Signature of Patient or Responsible Party

Date

Print Name

Relationship to Patient

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

_____ attempted to obtain patient's acknowledgement but was
unable to do so. The reason it was not obtained was _____.

Signature _____

Date _____

NO SHOW/MISSED APPOINTMENT POLICY

We, at Cancer Center Oncology Medical Group, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 619-644-3030

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at Cancer Center Oncology Medical Group and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Cancer Center Oncology Medical Group will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office.
6. If you have 3 "No-Show/Missed" appointments within a one-year time, dismissal from the practice will be considered.

***You will be notified by letter if the dismissal was approved.**

I have read and understand Cancer Center Oncology Medical Groups No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Cancer Center Oncology Medical Group appropriately if I have difficulty keeping my scheduled appointments.

Patient Name

Date of Birth

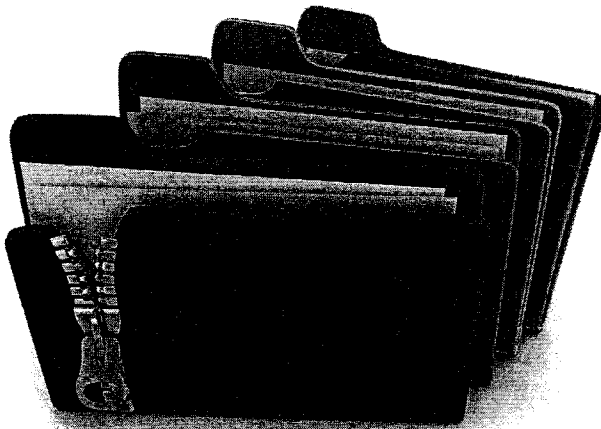
Date

Patient Signature or Parent/Guardian if minor

Relationship to Patient



P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413
(866) 866-0602 or (877) 735-2929 TTY/TTD
<http://dhcs.ca.gov/privacyoffice>



Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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Your Rights *continued*

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

***Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

***Example:** We use health information about you to develop better services for you.*

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

***Example:** We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

***Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety
-

Do research

- We can use or share your information for health research.
-

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
-

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
 - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
-

Address workers’ compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers’ compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Conduct outreach, enrollment, care coordination and case management

- We can share your information with other government benefits programs like Covered California for reasons such as outreach, enrollment, care coordination, and case management.
-

Appeal a DHCS decision

- We can share your information if you or your provider appeal a DHCS decision about your health care.
-

Apply for full scope Medi-Cal

- If you are applying for full scope Medi-Cal benefits, we must check your immigration status with the U.S. Citizenship and Immigration Services (USCIS).
-

Join a managed care plan

- If you are joining a new managed care plan, we can share your information with that plan for reasons such as care coordination and to make sure that you can get services on time.
-

continued on next page

Administer our programs

- We can share your information with our contractors and agents who help us administer our programs.

Comply with special laws

- There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice.
-

We will never market or sell your personal information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

- This notice applies to all DHCS programs, including Medi-Cal. For a full list of programs currently run by DHCS, please visit our website at www.dhcs.ca.gov/services.

For More Information

Please contact us to request a copy of this notice in other languages or to get a copy in another format, such as large print or Braille.

DHCS does not have full copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor, dentist, or health plan first.



DHCS Privacy Officer

P.O. Box 997413 MS 4721
Sacramento, CA 95899-7413

Phone: **(866) 866-0602** Option 1, or (877) 735-2929 TTY/TTD

Fax: (916) 440-7680

Email: privacyofficer@dhcs.ca.gov