

# 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



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: \_\_\_\_\_  
 Mr.  Miss  Marital status (circle one)  
 Mrs.  Ms. Single / Mar / Div / Sep / Wid / Other

Social Security #: \_\_\_\_\_ Birth Place: City, State, Country \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 M  F

Ethnicity/Race:  American Indian/Alaska Native  Asian  Black/ African American  Pacific Islander/Native Hawaiian  
 Hispanic/Latino  White  Other  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: \_\_\_\_\_ Yes \_\_\_\_\_ No Email: \_\_\_\_\_

Chose clinic because/Referred to clinic by (please check one box):  Dr.  Insurance Plan  Hospital  
 Family  Friend  Close to home/work  Yellow Pages  Other

Other family members seen here: \_\_\_\_\_

May we give any medical information/results: to your spouse:  Yes  No on your answering machine:  Yes  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:  Self  Spouse  Child  Other

Name of secondary insurance: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber's S.S. no.: \_\_\_\_\_ Group no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  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 \_\_\_\_\_

## 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>
<b>FATHER</b> _____		
<b>MOTHER</b> _____		
<b>SIBLING</b> _____		
<b>SIBLING</b> _____		
<b># OF SONS</b> _____	<b>ILLNESSES</b> _____	
<b># OF DAUGHTERS</b> _____	<b>ILLNESSES</b> _____	

**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><b><u>GENERAL</u></b></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><b><u>EYES</u></b></p> <p><input type="checkbox"/> BLURRED VISION</p> <p><input type="checkbox"/> DOUBLE VISION</p> <p><input type="checkbox"/> DIFFICULTY SEEING</p> <p><b><u>EARS, NOSE, THROAT</u></b></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><b><u>CARDIAC</u></b></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><b><u>RESPIRATORY</u></b></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><b><u>GASTROINTESTINAL</u></b></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><b><u>GENITO-URINARY</u></b></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><b><u>MUSCULO-SKELETAL</u></b></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><b><u>SKIN</u></b></p> <p><input type="checkbox"/> RASH</p> <p><input type="checkbox"/> OTHER SKIN COMPLAINTS</p> <p><b><u>NEUROLOGICAL</u></b></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><b><u>PSYCHIATRIC</u></b></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><b><u>HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC</u></b></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:

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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: \_\_\_\_\_

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

## 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.

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Signature of Patient or Responsible Party

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Date

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Print Name

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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.

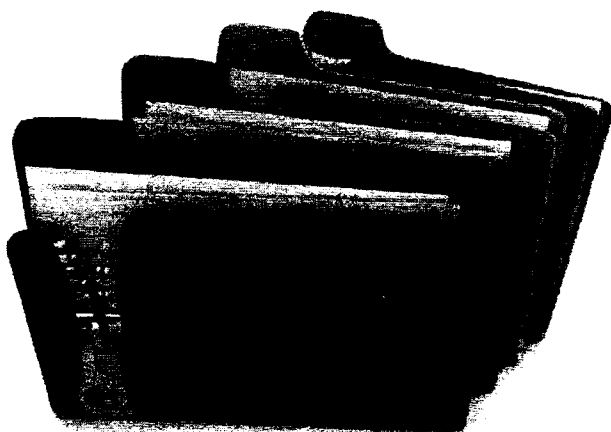
\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature or Parent/Guardian if minor

\_\_\_\_\_  
Relationship to Patient



## **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 an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record 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 information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is 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 say "yes" to all reasonable requests.

*continued on next page*

## 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.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

### 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/](http://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 your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- 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
- Most sharing of psychotherapy notes

**In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## 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.

**Treat you**

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

**Example:** A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

**Example:** We use health information about you to manage your treatment and services.

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

**Example:** We give information about you to your health insurance plan so it will pay for your services.

*continued on next page*

**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](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**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

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**Do research**

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

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**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.

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**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.

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**Work with a medical examiner or funeral director**

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

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**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

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**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.

## 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](http://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, in our office, and on our web site.

06/22/2017

**This Notice of Privacy Practices applies to the following organizations.**

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DEBBIE MASON, OFFICE MANAGER/SECURITY OFFICER 619-644-3030 619-644-3638