PLATINUM PROVIDERS
MEDICAL GROUP

Thank you for entrusting our providers and staff to service your healthcare needs. Please read the information contained in this packet carefully.

Eligibility & Insurance Card Copies:

- Our staff will run your current insurance coverage through an "Insurance Eligibility Portal" to ensure your insurance coverage is currently active and that all data on your insurance policy and card matches what is being presented on this packet. If there are any issues or concerns our front office staff will go over them with you.
- It is your responsibility to present any new insurance information at the time of your visit, as well as any changes to your personal information we have on file.
- Our front office staff is required to obtain a copy of the front and back of your Insurance Card(s).

Co-Pays, Co-Insurance and Deductibles:

- Our front office staff is required to collect all co-pays up front prior to your visit. Please be prepared to pay your co-pay via cash, check, and or credit card. Our front office staff is required to provide you with a receipt for your payment either by paper or via email.

Patient Cost Estimator:

- Our Front Office will run a "Patient Cost Estimator" based on your level of visit and any other medical procedures being performed. This will detail what your insurance will apply to any co-insurance or deductibles for the current year. Any estimated balance dues will be collected at the time of service. Payment plans can be arranged if needed.

Platinum Providers Medical Group requires one of the following on the patients file.

- A valid Credit Card that can be ran if your account has a balance over one hundred dollars ($100.00). We will run your card if there has been no response to the statements we mail out or the phone calls made by our billing staff. The Card will only be used to pay for co-pay's, co-insurances, deductibles, or non-covered service balances, after all insurance payments have been received and the portion is clearly the patient responsibility. Most patients receive their Insurance Explanation of Benefits (EOB) prior to our group receiving its EOB.
- We accept Care Credit at Platinum Providers Medical Group. You can use Care Credit to cover co-pays, co-insurance, deductibles, and non-covered services.

I have read the above and understand the Front Office policies of Platinum Providers Medical Group, Inc.

Patient Name: _____ Date of Birth: _____

Patient Signature (Parent or guardian if under 18): _____

Date Signed: _____

PLATINUM PROVIDERS
MEDICAL GROUP

Authorization for Credit Card on File Payment

Authorization

- Until further notice, I authorize Platinum Providers Medical Group to charge the patient-responsible balances (co-pays, co-insurance, deductibles, non-covered services, elective items) on my account to the following credit card.

Circle One

- Visa
- Mastercard
- Discover
- American Express

Last 4 Digits of My Credit Card

- _____

Expiration Date (mm/yy)

- _____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB) from my health insurance plan. The EOB will state any balance to be paid by me. I agree that Platinum Providers Medical Group may charge my credit card on file for the balance due when they receive a copy of the EOB from my health insurance plan. If the balance due is more than $100.00, I will receive a courtesy call prior to my card being charged.

- ❖ Debit Cards with these logos are acceptable, however, please be aware that we run an authorization only transaction for ($1.00) on the cards when storing them. Some banks may put this money on hold for up to 5 days or more. We highly recommend using a credit card if that is an option for you.

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____ Date Signed: _____

Email for Receipts: _____ CVMA Representative: _____

Platinum Providers Medical Group, Inc.
Patient Registration and Billing Information

Patient Name: _____ **DOB:** _____ **Birth Sex**: F • M

Gender Identity: Male • Female • Transgender Male • Transgender Female • Neither Male nor Female • Decline

Sexual Orientation: Lesbian, Gay, or Homosexual • Straight or Heterosexual • Bisexual • Something Else • Decline

Marital Status: Married •Divorced • Separated •Widowed •Single **Primary Physician**: _____

Preferred Language: English • Spanish • Other_____ **Email:** _____

Is Visit Due to an Accident? _____ **Work Injury?** _____

Patient Information

Street_____

City_____ State & Zip _____

Home #_____Cell#_____

SSN_____Drivers License#_____

Employer Name_____

Street_____

City_____ State & Zip_____

Work Phone No_____

Emergency Contact_____

Street_____

City_____ State & Zip_____

Phone_____

Relationship_____

Guarantor Information (If Patient is a Minor)

Name_____

Street_____

City_____ State & Zip_____

Home _____Cell#_____

SSN_____Drivers License_____

Date of Birth_____

Relationship to Patient_____

Employer Name_____

Street_____

City_____ State & Zip_____

Work Phone No_____

For Office Use Only

Date Received____/____/____ By_____

Insurance # 1 (Please Provide Card to Receptionist)

Insurance Company_____

Subscriber_____

Relationship_____

Address_____

City_____ State & Zip_____

Subscriber's Employer_____

Employer's Address_____

City_____ State & Zip_____

Policy No/Certification No_____

Group No & Plan_____

Subscriber's Date of Birth_____

Insurance # 2 (Please Provide Card to Receptionist)

Insurance Company_____

Subscriber_____

Relationship_____

Address_____

City_____ State & Zip_____

Subscriber's Employer_____

Employer's Address_____

City_____ State & Zip_____

Policy No/Certification No_____

Group No & Plan_____

Subscriber's Date of Birth_____

I authorize and give consent to Platinum Providers Medical Group, Inc., for general medical treatment.

I authorize Platinum Providers Medical Group, Inc., to furnish information concerning my care to my insurance company to process my claims.

I understand that I will be billed for any uncovered services and for any co-payment, co-insurance or deductible that is not paid by my insurance company.

Patient Signature (Parent or guardian if under 18): _____Date_____

***** ALL MEDICAL RECORDS ARE SAFEGUARDED AND CONFIDENTIAL *****

Name: _____ Age: _____ Date of Birth: _____

Family History	If Living Age Health	If Deceased Age at Death Cause	Please Circle Has any blood relative had Who	 no or yes
Father			Cancer	no or yes
Mother			Tuberculosis	no or yes
Brother or Sister 1.			Diabetes	no or yes
2.			Heart Trouble	no or yes
3.			High Blood Pressure	no or yes
4.			Stroke	no or yes
5.			Epilepsy	no or yes
Husband or Wife			Mental Illness	no or yes
Son or Daughter 1.			Suicide	no or yes
2.			Congenital Deformities	no or yes
3.			List any previous surgeries:	
4.				

Illnesses You Have Had

Measles or German Measles	No or Yes
Chickenpox or Mumps	No or Yes
Whooping Cough	No or Yes
Scarlet Fever or Scarlatina	No or Yes
Pneumonia or Pleurisy	No or Yes
Diphtheria or Smallpox	No or Yes
Influenza	No or Yes
Rheumatic Fever/Heart Disease	No or Yes
Arthritis or Rheumatism	No or Yes
Any bone or joint disease	No or Yes
Neuritis or Neuralgia	No or Yes
Bursitis, Sciatica, Lumbago	No or Yes
Polio or Meningitis	No or Yes
Bright's Disease or Kidney INF	No or Yes
Gonorrhea or Syphilis	No or Yes
Anemia or Jaundice	No or Yes
Epilepsy	No or Yes

Allergies: Are You Allergic To

Penicillin or Sulfa	No or Yes
Aspirin, Codeine or Morphine	No or Yes
Mycins or Other Antibiotics	No or Yes
Merthiolate or Mercurochrome	No or Yes
Any other Drugs	No or Yes
Any Foods	No or Yes
Adhesive Tap	No or Yes
Nail Polish or other Cosmetics	No or Yes
Tetanus, Antitoxin or Serums	No or Yes

Migraine Headaches	No or Yes
Tuberculosis	No or Yes
Diabetes or Cancer	No or Yes
High or Low Blood Pressure	No or Yes
Nervous Breakdown	No or Yes
Food, Chemical, Drug Poisoning	No or Yes
Hay Fever or Asthma	No or Yes
Hives or Eczema	No or Yes
Frequent Colds/Sore Throats	No or Yes
Frequent Infections/Boils	No or Yes
Any other Disease	No or Yes

Review of Systems: Please Check Those You Have Had

Injuries: Have You Had Any

Broken bones	No or Yes
Sprains or Dislocations	No or Yes
Lacerations (Extensive)	No or Yes
Concussion or Head Injury	No or Yes
Ever been knocked out	No or Yes

Transfusions: Have You Ever Had

Blood or Plasma Transfusion	No or Yes

Weight

Current_____ One year ago_____
Maximum _____ When_____

Habits: Do You

Sleep Well?	No or Yes
Use Alcoholic Bev?	No or Yes
If yes, Everyday?	No or Yes
Smoke?	No or Yes
If yes, How much?	_____
Exercise Enough?	No or Yes
Diet well balanced?	No or Yes

List Any Drugs or Medications You Take Regularly or Frequently

_____
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- ○ Eye Disease
- ○ Eye Injury
- ○ Impaired Sight
- ○ Ear Disease
- ○ Ear Injury
- ○ Impaired Hearing
- ○ Trouble w/ Nose
- ○ Trouble w/ Sinuses
- ○ Trouble w/ Mouth
- ○ Trouble w/ Throat
- ○ Fainting Spells
- ○ Loss of Consciousness
- ○ Convulsions
- ○ Paralysis
- ○ Frequent/Severe Headaches
- ○ Dizziness
- ○ Depression
- ○ Anxiety
- ○ Hallucinations
- ○ Enlarged Glands
- ○ Goiter or Enlarged Thyroid
- ○ Skin Disease
- ○ Swelling of hands, Feet or Ankles
- ○ Varicose Veins
- ○ Extreme Tiredness or Weakness
- ○ Chronic or Frequent Cough
- ○ Chest Pain or Angina Pectoris

- ○ Spitting up of Blood
- ○ Night Sweats
- ○ Shortness of Breath
- ○ Palpitations or Fluttering Heart
- ○ Kidney Disease or Stones
- ○ Bladder Disease
- ○ Albumin, Sugar, Pus, etc in Urine
- ○ Difficulty Urinating
- ○ Stomach Trouble or Ulcers
- ○ Indigestion
- ○ Liver or Gallbladder Disease
- ○ Colitis or other Disease
- ○ Appendicitis
- ○ Hemorrhoids or Rectal Bleeding
- ○ Constipation or Diarrhea
- ○ Recent Change in Bowel Action or Stools
- ○ Recent Changes in Appetite or Eating Habits

Women Only: Menstrual History

Age at Onset_____

- ○ Regular
- ○ Irregular
- ○ Heavy Flow

Cycle: _____ Days (From Start to Finish)
Usual Duration _____Days
Pain or Cramps No or Yes
Date of Last Period _____
Number of Pregnancies? _____
Children Born Alive? _____
Stillbirths? _____

Platinum Providers Medical Group, Inc.

Consent for purposes of Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health, history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action to reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

_____ _____

Signature or Patient/Legal Representative Date Relationship to Patient

_____ _____

Print Name of Patient Patient Date of Birth

Please list all dependents, relationship, and date of birth (NO SPOUSE)

Name	Relationship	Date of Birth

Office Use Only: **Accepted** **Denied**

_____ _____

Authorized Signature Date

PLATINUM PROVIDERS
MEDICAL GROUP

Telemedicine Informed Consent Form

Please check as you understand each item in this consent form *

- ☐ I understand that telemedicine is the use by a health care provider of communication technologies available such as the internet for delivery of health care services via audio and video regardless to the location of the parties in communication.
- ☐ I understand the benefits with the use of telemedicine, as well as its limitations whereas there can be no guarantee to the results of all treatments made through this medium.
- ☐ I understand the limitations with the use of telemedicine where it cannot be fully equal to face-to-face mode of treatment and such delays may incur due to possible cases of intermittent communication that may arise and which the telemedicine service provider is of no fault.
- ☐ I understand that there are state laws that help protect my privacy by standardizing confidentiality and information security that apply to telehealth and telemedicine consultations such as HIPAA. However, in case my insurance need access to my medical information, I hereby grant release of information requested to my insurance provider and/or its representatives.
- ☐ I understand that my participation is voluntary, and I have the right to withhold, or withdraw my consent to the use of the telemedicine anytime. I understand that my withdrawal does not affect any future treatment with the provider.
- ☐ I am aware and shall solely be responsible for any charges incurred with the use of telemedicine and shall inform the telemedicine service provider the mode of payment I shall prefer.
- ☐ I understand that I this telemedicine informed consent form has sole jurisdiction in the state of California and therefore I must be a resident in California to be treated through telemedicine.

By signing this form, I affirm my voluntary consent to this telemedicine engagement. I understand that each item above was explained to me. I was given the opportunity to ask my questions and the questions were answered accordingly and to my satisfaction.

_____ _____

Patient Name **Date of Birth**

_____ _____

Signature of Patient (Parent/Guardian if under 18) **Date Signed**

PLATINUM PROVIDERS
MEDICAL GROUP

Request of Medical Information

Authorization

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Patient Social Security Number: _____Patient Telephone Number: _____

Record Holder

Hospital, Medical Group, Physician Name:
_____

Hospital, Medical Group, Physician Telephone Number:
_____

Hospital, Medical Group, Physician Fax Number:
_____

Records May Be Released To:

Platinum Providers Medical Group, Inc.
6900 Brockton Ave., Ste 100
Riverside, CA 92506
TN: 951-781-3800
Fax: 951-781-1973

Type of Information

_____ Discharge Summary _____ Emergency Dept Reports _____ Psychiatric Records

_____ Progress Notes _____ Laboratory Results _____ Billing Information

_____ Doctor's Orders _____ Any and All Records _____ Radiology/Nuclear Med Reports

_____ History/Physical Exam _____ Treatment Alcohol/Drug Abuse _____ Operative/Procedure Reports

_____ Consultation Reports _____ HIV Test Results (Human Immunodeficiency Virus)

_____ Other (Please Specify):

_____

Dates of Service

- From: ___/___/____
- To: ___/___/____

Use of Information

The individual or entity identified above is permitted to use my information for the following purposes:
(Please initial all that apply)

_____Transfer of Care _____ Second Opinion _____Personal _____Insurance _____Legal

_____ Continuing Care _____ Other (Please Specify): _____

Duration

- This authorization is valid for one year from the date next to my signature, unless otherwise noted here: ___/___/____

Additional Copy

- I further understand that I have a right to receive a copy of this authorization upon my request.

Redisclosure

- I understand that once received, my records will be subject to re-disclosure and my no longer be protected by federal privacy laws.

Revocation

- This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt but will not be effective to the extent that the Requester is specifically required or permitted by law.

Explanation

- I understand that my treatment is no way conditioned on whether I sign the authorization and that I may refuse to sign it.

Signature

Patient Name Printed: _____ Patient Date of Birth: _____

Patient Signature: _____ Date Signed: _____

If signed by someone other than the patient, indicate relationship to patient: _____

Witness Signature: _____ Date/Time: _____

- ❖ Legal documentation along with a valid ID must be provided to prove authority to sign on the patient's behalf

PLATINUM PROVIDERS
MEDICAL GROUP

Physical/Wellness Exam vs Office Visit

We would like to help our patients understand the difference between a physical/wellness exam and an office visit. Most appointments are generally scheduled as office visits. An "office visit" is an appointment time to discuss new or existing problems. You can discuss up to three with your provider per visit. The visit may include prescribing medications, ordering additional tests like lab or x-ray, in-office procedures like an EKG, referrals to specialists, or discussing other treatment options.

A "physical" or "wellness exam" is a thorough review of your general well-being. The doctor will review your medical problems, perform a complete physical examination, and make recommendations concerning your health. This may include general recommendations regarding diet and exercise, age appropriate immunizations and cancer screening exams such as a pap test, prostate exam, breast exam and/or screening lab work.

Occasionally, you may be seen for both a physical and an office visit on the same day. This means that you satisfy the requirements for both types of visits during one appointment. If you are scheduled for a physical/wellness exam but also discuss a problem that is separate from your physical/wellness exam, you will be billed for both a physical/wellness exam and office visit. If during your exam the doctor determines an ongoing chronic medical problem is "out of control" the provider can choose to address that issue at the appointment and schedule the physical/wellness exam for a later time. It is important to know that if anything is addressed outside of the "physical/wellness" guidelines you will be charged a copayment (due at the time of service) and/or coinsurance or deductible charges.

If you have any questions regarding your visit today, please feel free to ask one of our front office staff members. Please sign below that you understand the above information regarding the difference between physical/wellness exams and an office visit.

_____

Patient Name (Print Clearly) Patient Date of Birth

_____

Patient Signature Date

Platinum Providers Medical Group, Inc.

Eligibility Guarantee Form

(One Form per Member)

I, _____, understand that I am eligible for Health Plan benefits with
(Subscriber's Name)

_____ as of _____ through
(Name of Health Plan) (Month) (Day) (Year)

_____. I have selected Platinum Providers Medical Group as my medical group
(Name of Employer)

and Dr. _____ as my Primary Care Physician. I understand that if the above is
(Name of Physician/Provider)

not true, or if I am not eligible under the terms of my health plan and/or employer groups Medical and Hospital subscriber agreement, I am financially responsible for all charges for services rendered. Additionally, and assuming my eligibility for benefits is not established as set forth above, I agree to pay for all services within 60 days of receiving a bill from the physician listed above.

_____ _____
Name of Patient Patient Date of Birth

_____ _____
Signature of Patient (Parent or guardian if under 18) Date

Office Use Only

Patients Name: _____ DOB: _____

Member ID or Subscriber SSN: _____

Eligibility Verified by: _____

Member Service Rep: _____

Confirmation#: _____

Member Verified? Yes No Employer Group Verified? Yes No

ADVANCE HEALTH CARE DIRECTIVE

Dear Patient,

As your physician, we are requested to ask any patient over the age of 18, if they have an existing Advance Health Care Directive, so that we can incorporate the information into your medical records. You are not required to give us this information, but we are required to ask. Please complete this form and return to the receptionist.

Thank you

Patient Name: _____ Social Security#: _____

Patient Signature: _____ Date: _____

- Do you have an Advanced Health Care Directive? ( ) Yes ( ) No
- If yes, please indicate which type of Directive?
  - Durable Power of Attorney for Health Care ( )
  - California Natural Death Act ( )
  - Living Health Care Will ( )
  - Other: _____ ( )
- Will you bring us a copy of your Directive? ( ) Yes ( ) No
- I decline to answer these questions ( ) Yes ( ) No

INTERNAL OFFICE USE ONLY

Type of Health Care Directive Received:	**Date Received**
Durable Power of Attorney for Health Care	_____
California Natural Death Act	_____
Living Health Care Will	_____
Other: _____	_____

A Message to Our Patients About Arbitration

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur because of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled Physician-Patient Arbitration Agreement. By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of a court trial and the publicity which may accompany judicial proceedings.

Thank you

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether the subject of any existing court action, shall also be resolved in arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relation to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of the arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVIN UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: *Platinum Providers Medical Group and Affiliated Providers*

Physician's or Authorized Representative's Signature

By: _____

Patient's or Patient Representative's Signature

By: Platinum Providers Medical Group and Affiliated Providers

Print Name of Physician, Medical Group, or Association Name

By: _____

Print Patient's Name

Date: _____

Date: _____

_____

(If Representative Print Name/Relationship to Patient)

NOTICE OF PRIVACY PRACTICES

Platinum Providers Medical Group, Inc.

Effective Date: March 1, 2018

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
4. **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.

5. **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.
6. **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.
7. **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.
8. **Health Oversight Activities**. We may and are sometimes required by law to disclose your health information to health oversight agencies during audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by federal and California law.
9. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information during 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.
10. **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.
11. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
12. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
13. **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 agreed to the disclosure on behalf of yourself or your dependent.
14. **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.
15. **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.
16. **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.
17. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to an 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.

E. Complaints
Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to your physician's office manager.

If you are not satisfied with the way this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Platinum Providers Medical Group
Nondiscrimination Notice

Platinum Providers Medical Group (PPMG) and its covered entities comply with applicable Federal civil rights laws and does not exclude, deny benefits to, or otherwise unlawfully discriminate based on race, color, gender, sexual orientation, gender identity, national origin, medical condition, physical handicap or disability, mental condition, veteran's status, or age in admission to, participation in or receipt of the services and benefits under any of its programs and activities.

PPMG does not exclude people or treat them differently because of race, color, gender, sexual orientation, gender identity, national origin, medical condition, physical handicap or disability, mental condition, veteran's status, or age. Also prohibited is retaliation of any kind against individuals who file complaints in good faith or who assist in a PPMG investigation.

If you believe that you have been unlawfully discriminated against, you can file a grievance with PPMG by phone or in writing.

- By phone: Call PPMG's Director of Quality Management at 951-808-6240 (if you cannot speak or hear well please call 711)
    - Monday through Thursday, 8 a.m. to 5 p.m.
    - Friday, 8 a.m. to 2 p.m.
- In writing: Mail complaint to PPMG's Director of Quality Management
    - P.O. Box 5089, Norco, CA 92860

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing or electronically:

- By phone: Call 916-440-7370. If you cannot speak or hear well, please call 711.
- In writing: Fill out a complaint form or write a letter and send it to Deputy Director, Office of Civil Rights
    - Department of Health Care Services, Office of Civil Rights

      P.O. Box 997413, MS 0009

      Sacramento, CA 95899-7413
    - Complaint forms are available at

      http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing or electronically:

- By phone: 1-800-368-1019 (TDD: 1-800-537-7697).
- In writing: Fill out a complaint form or send a letter to U.S. Department of Health and Human Services
    - 200 Independence Avenue SW, Room 509F, HHH Building

      Washington, DC 20201.
    - Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
- Electronically: Visit the Office for Civil Rights Complaint Portal at

  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.