PATIENT REGISTRATION

LEGAL PATIENT NAME (Last, First, MI):	**PREFERRED NAME:**	**BIRTHDATE:**
STREET ADDRESS (Please include apt/unit number):	**PATIENT SOCIAL SECURITY #:**	
CITY:	**STATE:**	**ZIP CODE:**
HOME PHONE:	**OK TO LEAVE DETAILED MESSAGES? [ ] Yes [ ] No**	
CELL PHONE:	**OK TO LEAVE DETAILED MESSAGES? [ ] Yes [ ] No**	
EMAIL:		

PATIENT INFORMATION

GENDER AT BIRTH: **[ ] Male [ ] Female [ ] Decline**	**GENDER IDENTITY:**	**SEXUAL ORIENTATION** **[ ] Heterosexual [ ] Homosexual [ ] Bisexual [ ] Other: _____ [ ] Decline**
PRIMARY LANGUAGE:	**ETHNICITY:** **[ ] Hispanic or Latino** **[ ] Non-Hispanic or Latino** **[ ] Jewish** **[ ] Other: _____** **[ ] Decline**	**RACE:** **[ ] Asian: _____** **[ ] Black/African American** **[ ] Hispanic/Latino** **[ ] Native Hawaiian or Pacific Islander** **[ ] White/Caucasian** **[ ] Other: _____** **[ ] Decline**
LEGAL MARITAL STATUS: **[ ] Single [ ] Married** **[ ] Separated [ ] Divorced** **[ ] Widowed** **[ ] Decline**		
HAVE YOU EVER SEEN DR. PURCOTT BEFORE? [ ] Yes [ ] No [ ] Unsure	**YEAR LAST SEEN:**	
LOCATION(S) WHERE YOU HAVE SEEN HER? **[ ] Vista Way OB/Gyn Medical Group [ ] Scripps Coastal Medical Group [ ] Palomar Health Medical Group [ ] Pacific View OB/GYN Medical Group**		

POLICY HOLDER (if different than patient)

NAME (Last, First, M.I.):	**SSN:**	**BIRTH DATE:**	**LANGUAGE:**	**SEX:** **[ ] Male [ ] Female**
BILLING ADDRESS:	**CITY:**	**STATE:**	**ZIP:**	
STREET ADDRESS (if different than billing):	**CITY:**	**STATE:**	**ZIP:**	
HOME PHONE:	**WORK PHONE:**	**CELL PHONE:**	**EMAIL:**	
RELATIONSHIP TO PATIENT:				

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY:	**POLICY#:**	**GROUP#:**	**ARE YOU THE SUBSCRIBER?: [ ] Yes [ ] No**
NAME OF POLICY HOLDER:	**EFFECTIVE DATE:**	**SPECIALIST COPAYMENT:**	
ADDRESS OF INSURANCE COMPANY:	**CITY:**	**STATE:**	**ZIP:**

REFERRAL INFORMATION

NAME OF REFERRING PHYSICIAN:	**PRIMARY CARE PHYSICIAN:**

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Paps & Martinis • Gynecology & Aesthetics •Kari Lynn Purcott MD to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct.

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

ASSIGNMENT OF BENEFITS: I thereby assign all benefits payable by my insurance company to Paps & Martinis • Gynecology & Aesthetics •Kari Lynn Purcott MD.

Patient/Guardian Signature	**Date**	**Relationship to Patient**	**Patient Name (Please Print)**	**Date of Birth**

Patient Name:		Date of Birth:	

MEDICAL HISTORY QUESTIONNAIRE

*PLEASE TELL US THE MAIN REASON FOR YOUR VISIT:

*LIST ANY KNOW MEDICATION ALLERGIES BELOW: [ ] No Known Drug Allergies

Medication:	Reaction:	Medication:	Reaction:

*PREFERRED PROVIDERS:

Type	Name of Facility	Address and/or City	Phone Number
*Preferred Pharmacy:			
*Preferred Laboratory:			
*Preferred Radiology			

*PLEASE LIST MEDICATIONS CURRENTLY TAKING BELOW: [ ] Not Taking Any Medications

Medication:	Strength:	Dosage:	Medication:	Strength:	Dosage:

*Have you ever been diagnosed with any of the following? Please check the box. [ ] No Past Medical History

	Anemia		Diabetes		High Cholesterol		Other Disorder:
	Arthritis		Down's Syndrome		Inherited Genetic Disorder		
	Asthma		Epilepsy		Kidney Disease		Recurrent Pregnancy Loss
	Back Pain		Gallstones		Kidney Stones		Seizures
	Bladder Infections (UTI)		Head Injury		Maternal Metabolic Disorder		Sickle Cell Trait
	Bleeding Tendency		Heartburn/Reflux		Mental Disability		STD:
	Cancer:		Heart Disease		Migraine Headaches		Tay Sach's Carrier
	Congenital Heart Defect		Hemophilia		Muscular Dystrophy Disorder		Thalassemia Carrier
	Cystic Fibrosis Carrier		Hepatitis		Neural Tube Defect		Thyroid Disorder
	Depression		High Blood Pressure		Osteoporosis		Tuberculosis

*Family Medical History (Check all that apply): [ ] No Pertinent Family History [ ] Family History Unknown

	No Known Problems	Cancer	Diabetes	Heart Disease	Hypertension	Psychiatry	Stroke	Thyroid	Other
Mother									
Father									
Daughter									
Son									
M. Grandma									
M. Grandpa									
P. Grandma									
P. Grandpa									
Sister									
Brother									

Patient Name:	Date of Birth:

*Prior Surgeries (Type and Year): [ ] No History of Surgeries			
Type of Surgery	**Year**	**Type of Surgery**	**Year**

*Prior Hospitalizations (Reason and Year): [ ] No Previous Hospitalizations			
Reason	**Year**	**Reason**	**Year**

Gynecological/Obstetrical History					
Name of previous OB/GYN (Please Print):					
Are you still menstruating? [ ] Yes [ ] No					
Date of LMP (Last Menstrual Period):					
Menstrual Cycles:	**Regular? [ ] Yes [ ] No**	**Irregular? [ ] Yes [ ] No**	**Painful? [ ] Yes [ ] No**		
Method of Contraception:	**[ ] None [ ] Abstinence [ ] Birth Control Pills [ ] Condom [ ] Depo [ ] IUD: [ ] Nexplanon [ ] Rhythm [ ] Tubal Ligation (Date):**				
Are you satisfied with your current method of birth control? [ ] Yes [ ] No					
If no, please explain:					
Are you interested in the Gardasil (HPV-Human Papilloma Virus) Vaccine? [ ] Yes [ ] No					
Date of Last Pap Smear?		**History of Abnormal Pap Smear?**	**[ ] Yes [ ] No Year:**	**History of exposure to HPV?**	**[ ] Yes [ ] No Year:**
Date of Last Mammogram?		**History of Abnormal Mammogram?**	**[ ] Yes [ ] No Year:**		
Have you ever been pregnant? [ ] Yes [ ] No					

Total # of Pregnancies		**# of Term Births (>37 Weeks)**		**# of Premature Births (<37 Weeks)**		**# of Abortions**		**# of Miscarriages**		**# of Ectopics**		**# of Living Children**	

Date (Mo/Day/Yr)	**Duration of Pregnancy (Weeks)**	**Birth Weight (lbs)**	**Gender**	**Type of Delivery**	**Epidural (Yes/No)**	**Place of Delivery**	**Complications**

I have entered all the information to the best of my knowledge and verify that the information is accurate and true.

Print Patient Name:	**Signature of Patient or Legal Representative:**	**Date:**

Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott, MD
2095 W. Vista Way, Suite 106 | Vista, CA 92083

Patient Financial Agreement

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

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

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

Initials: ____ Cash Pay Patients: The amounts you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, X-ray tests, any injections, special procedures or additional office visit charges.

Initials: _____ Claims Submission: As a courtesy**, Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott**, will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until the claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible for providing a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection
agency.

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

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

Initials: ____ Assignment of Benefits: Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to **Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott** for all services rendered.

Initials: ____ Missed Appointments: Please note a $50.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Initials: _____ I have read and understand the above statements.

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

I agree to comply with the financial policies of **Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott**, MD and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____
Patient / Guardian Signature Date

_____ _____
Patient Name (Please print) Date of Birth

Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott, MD
2095 W. Vista Way, Suite 106 | Vista, CA 92083

Advance Directive Information

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

Your Rights as a Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott Patient
You have a legal right to make known your wishes about your medical care, including the right to accept or refuse treatment. The document "Advance Health Care Directive" is a means to specify your wishes and to make them legally binding.

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

How do I find out more?

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

How do I obtain an Advance Healthcare Directive form?

- The California Medical Association – Kit available for nominal fee (currently $6)
  1201 J St. STE 200
  Sacramento, CA 95814
  Phone: 800.786.4262 Fax: 916.551.2036
- Obtain the form on-line free of charge at: http://ag.ca.gov/consumers/pdf/AHCDS1.pdf

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

Patients: Please check the appropriate box(es):

[ ] I have an Advance Directive and/or POLST. I will provide **Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott** with a copy. (Give the copy to one of our staff or mail to: 2095 W. Vista Way, Ste 106, Vista, CA 92083, ATTN: Medical Records.)

[ ] I have an Advance Directive/POLST but do not wish to provide **Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott** with a copy.

[ ] I do not have an Advance Directive/POLST.

_____ _____
Signature of Patient or Patient's Legal Representative Date

Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott, MD
2095 W. Vista Way, Suite 106 | Vista, CA 92083

Authorization for Use or Disclosure of Health Information

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

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

I, _____ (patient) (please print) hereby authorize **Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott** to release any and all information about my health, medical condition or billing for services to members of family or other persons, as specified below. This includes verbal discussions with the medical/nursing staff and copies of my medical record.

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

THE PURPOSE OF THIS RELEASE IS

[ ] At my request [ ] Continuing medical care [ ] Other: _____

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

_____

_____

_____

_____

_____

Authorization for Use or Disclosure of Health Information

EXPIRATION OF AUTHORIZATION

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

PATIENT RIGHTS

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

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

Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott
2095 West Vista Way, Suite 106
Vista, CA 92083

If I revoke this authorization, the revocation will not have any effect on actions taken prior to **Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott** receiving the revocation.

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

› I have a right to a copy of this Authorization.

_____ _____
Patient / Guardian Signature Date

_____
If Legal Representative, State Relationship to Patient

_____ _____
Patient Name (Please print) Date of Birth

Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott, MD
2095 W. Vista Way, Suite 106 | Vista, CA 92083

No-Show, Late, and Cancellation Policy

Dear Patient,

We understand that at times, due to other obligations, you may need to cancel or reschedule your appointment. However, in order to better serve our patients, we have instituted a clinic policy to keep our patients, doctors, and staff on time.

In the event that you might need to cancel or reschedule your appointment:

Initials: ____ 1) Please call us at (760) 295-0664 at least **24 hours in advance**. If we miss your call, please leave us a message and we will return your call and assist you with rescheduling.

Initials: ____ 2) **New Patients**, please arrive 30 minutes before your scheduled appointment time in order to complete the appropriate paperwork and for the check-in process.

Initials: ____ 3) **Established Patients**, please arrive 15 minutes before your scheduled appointment time in order to complete the check-in process and to update any changes.

Initials: ____ 4) It is important to keep in mind, that if you are **15 minutes or more minutes late** to your appointment, the appointment will be rescheduled.

Initials: ____ 5) Please note a **$50.00 cancellation fee** will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Please initial the above statements confirming that you understand and agree to our office policy.

I agree to comply with the No-Show, Late, and Cancellation Policy of **Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott**, MD and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____
Patient / Guardian Signature Date

_____ _____
Patient Name (Please print) Date of Birth

Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott, MD
2095 W. Vista Way, Suite 106 | Vista, CA 92083

Notice Of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT

PATIENT INFORMATION

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Patient / Guardian Signature Date

_____
Patient Phone (XXX-XXX-XXXX)

By signing this form, the patient acknowledges receipt of the "Notice of Privacy Practices" of Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information. We encourage you to read it in full.

I acknowledge receipt of the "Notice of Privacy Practices" of Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott.

_____ _____
Patient / Guardian Signature Date

_____
If legal representative, state relationship to patient

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

My email address is: _____

Paps & Martinis • Gynecology & Aesthetics • Kari Lynn Purcott, MD
2095 W. Vista Way, Suite 106 | Vista, CA 92083

Effective April 14, 2003 Revised September 10, 2013; March 23, 2015; July 29, 2019

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Pease review it carefully.

If you have any questions about this notice, please contact Paps & Martinis at (760)295-0664.
This notice describes Paps & Martinis' practices and that of:
-Any health care professional authorized to enter information into your health record.
-All departments and clinic sites of Paps & Martinis.
-Any member of a volunteer group allows us to help you while you are in our care.
-All employees, staff and other Paps & Martinis personnel.
-Affiliated Physicians
All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.
The providers participating in this notice (referred to as "we") understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive during your visit with us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by any of the Paps& Martinis sites or affiliated entities, whether made by Paps & Martinis personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice tells you about the ways we may use and disclose your medical information. This notice also describes your rights and certain obligations we have regarding the use and disclosure of medical information.
We are required by law to make sure that medical information that identifies you is kept private (with certain exceptions), to notify you of our legal duties and privacy practices with respect to medical information about you, to notify you if a breach of your medical information occurs, and to follow the terms of the notice of privacy practices currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST
We may disclose information when requested by you. This disclosure at your request may require written authorization by you.

Treatment — We may use medical information about you to provide you with medical treatment or services. We may disclose medical Information about you to doctors, nurses, technicians, pharmacists, health care students or other Paps & Martinis personnel and workforce members who are involved in providing for your well-being during your visit with us. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Additionally, the doctor may need to tell the dietitian if you have diabetes so we can arrange for appropriate meal Is. Different departments within Paps & Martinis also may share medical information about you to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside of Paps & Martinis who may be involved in your medical care after you leave us, such as skilled nursing facilities, home health agencies and physicians or other practitioners, including, without limitation, your primary care provider, so they can provide care or coordinate continuing care.

For Payment — We may use and disclose your medical information so that the treatment and services you receive at our facilities or from us may be billed and payment collected from you, an insurance company, a third party or a collection agency For example, we may need to give information about a medical service you received at a PHMG clinic to your health plan so it will pay us or reimburse you for the medical service. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other sources of payment to practitioners outside the hospital who are involved in your care, to assist them in obtaining payment for the services they provide to you.

For Health Care Operations — We may use and disclose medical information about you for health care and business operations, a variety of activities necessary to run our health care facilities and ensure all our patients receive quality care. For example, we may use medical information to review the quality and safety of our treatment and services, to evaluate the performance of our staff in caring for you, or for business planning, management and administrative services. We may also use and disclose your medical information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called business associates and are required by law to keep your medical information confidential. We may also disclose information to doctors, nurses, technicians, medical students and other hospital personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Fundraising Activities — We use information about you or disclose such information to a foundation related to Paps & Martinis, to contact you in efforts to raise money for our health care organization and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

Marketing and Sale — Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

To Individuals Involved in your Care or Payment for your Care —We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps to pay for your care. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so your family can be notified about your condition, status and location.

For Research — Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information does not leave our facilities or offices.

As Required by —We will disclose medical information about you When required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety — We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Psychotherapy Notes — Most uses and disclosures of psychotherapy notes require your authorization.

Organ and Tissue Donation—We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military & Veterans — If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation — We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Activities may disclose medical information about you for public health activities. These activities generally include the following:
-To prevent or control disease, injury or disability; To report births and deaths.
-To report regarding the abuse or neglect of children, elders and dependent adults.
-To report reactions to medications or problems with products; To notify people of recalls of products they may be using.
-To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
-To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
-To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Health Oversight Activities —We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure.
These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes — If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to allow you to obtain an order protecting the information requested.

Law Enforcement — May release medical information if asked to do so by a law enforcement official:
In response to a court order, subpoena, warrant, summons or similar process.
To identify or locate a suspect, fugitive, material witness or missing person.
About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; > About a death we believe may be the result of criminal conduct; About criminal conduct at our facility(ies); and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners Medical Examiners and Funeral Directors —We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities —We may release medical information about you to authorize federal officials for intelligence. counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others — We may disclose medical information about you to authorized federal officials who may conduct investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates— If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official as authorized or required by law. This disclosure would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Special Categories of Information — In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information — e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse.

Health Information Exchange (HIE) — We may share your health information electronically with other organizations where you receive health care. Sharing information electronically is a faster way to get your health information to the health care providers treating you. HIE participants are required to meet rules that protect the privacy and security of your health and personal information.

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

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION WE MAINTAIN ABOUT YOU
You have rights regarding the medical information we maintain about you. To exercise your rights regarding medical information we maintain about you, you must submit a written request to Paps & Martinis, 2095 W Vista Way, Ste 106, Vista, CA 92083.

RIGHT TO INSPECT AND COPY You have the right to inspect and/or obtain a copy of your medical information, including lab test results. You can ask for an electronic or paper copy of your medical information. We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. RIGHT TO AMEND If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Paps & Martinis. Your request must be made in writing, and you must provide a reason that supports your request. We may deny your request as authorized by law. Even if we deny your request for amendment, you have the right to submit a statement of disagreement.

RIGHT TO AN ACCOUNTING OF DISCLOSURES You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, and with other exceptions pursuant to law. Your request must state a time which may not be longer than six years and may not include dates before April 14, 2003. The first Est you request Within a 12-month period WII Ee fee. For additional lists, we may charge you for the costs of providing the list.

RIGHT TO REQUEST RESTRICTIONS You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations; for use in a facility directory; or to family members and Others involved in your care. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or Insurer), have paid for the item or service out of pocket in full.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS You have the right to request that we communicate with you about medical matters •n a certain way or at a certain location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
RIGHT TO A PAPER COPY OF THIS NOTICE You have the right to a paper copy of this notice upon request. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website: PurcottMD.com Changes to this Notice —We reserve the right to change this notice at any time, and to make the new notice effective for all medical information we maintain, including medical information we already have about you as well as any information we receive in the future. We will post a copy of the current note in all of our departments and clinic sites. Complaints — If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by contacting the Privacy Officer by telephone at (760) 295-0664 or in writing to Paps & Martinis, ATTN Privacy Officer, 2095 W Vista Way Suite 106, Vista, CA 92083. You will not be penalized or retaliated against for filing a complaint.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.