Synergy Specialists

SDMI Orthopedic
Jonathan Myer, MD
4910 Directors Pl Suite 350
San Diego, CA 92121
Phone: (858) 453-7364
Fax: (858) 453-7314

Health History Questionnaire

Name: _____ Date: _____ Age: _____

Family Physician: _____ Phone: _____ Fax: _____

Pharmacy: _____ Phone: _____ Fax: _____

History of Present Illness:

Reason for Today's Visit: ☐ Left ☐ Right _____

Date of Injury or Onset: _____

Was it caused by any specific injury/trauma? Yes/No If yes, please describe:

_____

_____

Severity: 0 (zero) being no pain - 10 (ten) being the worst pain imaginable 0 1 2 3 4 5 6 7 8 9 10

Frequency of pain: ☐ Intermittent ☐ Constant

What best describes your pain?: ☐ Dull ache ☐ Sharp pain ☐ Burning sensation ☐ Other: _____

Symptoms:

☐ Pain ☐ Weakness ☐ Stiffness ☐ Swelling ☐ Clicking ☐ Popping ☐ Instability ☐ Locking

☐ Giving Way ☐ Tingling ☐ Numbness ☐ Pain at night ☐ Other: _____

Aggravating factors:

☐ Overhead Activities ☐ Repetitive Movement ☐ Physical Activity ☐ Prolonged Standing ☐ Walking

☐ Running ☐ Bending ☐ Standing from seated position ☐ Other: _____

Alleviating factors:

☐ Rest ☐ Ice ☐ Heat ☐ Medications ☐ Elevation ☐ Wearing a brace ☐ Other: _____

Do you use any of the following:

☐ Cane ☐ Crutches ☐ Wheelchair ☐ Walker ☐ Knee Scooter ☐ Other: _____

What treatment have you had for this current problem?

☐ Physical Therapy ☐ Injections ☐ Splint/Brace ☐ Chiropractor ☐ Acupuncture ☐ Massage ☐ Splint/Brace

☐ Injections ☐ Home Exercise Program/Gym ☐ Other: _____

What previous tests and where have you had for this current problem?

☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG ☐ Where? _____ Other: _____

What previous surgery have you had for this current problem? ☐ No Surgery

Procedure Type: _____ Date of Surgery: _____

Patient Present/Past Medical History:

Please check any medical conditions you are currently being treated for or have been treated for in the past.

Yes	No		Yes	No	
☐	☐	Heart disease	☐	☐	High blood pressure
☐	☐	Angina or heart-related chest pain	☐	☐	Diabetes
☐	☐	High Cholesterol	☐	☐	No Stroke
☐	☐	Irregular heartbeat or arrhythmia	☐	☐	Tuberculosis
☐	☐	Thyroid disorder	☐	☐	Anemia
☐	☐	Liver problems, cirrhosis or hepatitis	☐	☐	Epilepsy or seizures
☐	☐	Lupus or rheumatoid arthritis	☐	☐	HIV or AIDS
☐	☐	Lung disease (asthma, emphysema or COPD)	☐	☐	Leg clots
☐	☐	Stomach ulcers, digestive problems or GERD	☐	☐	Bleeding disorders

Other _____

Drug Allergies: ☐ None

Medication _____ Type of Reaction _____

Medication _____ Type of Reaction _____

Medication _____ Type of Reaction _____

Are you allergic to latex products? ☐ Yes ☐ No Are your immunizations current? ☐ Yes ☐ No

Social History:

Height: _____ Weight: _____ Dominate Hand: ☐ Left ☐ Right

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Occupation: _____

☐ Yes ☐ No Tobacco Use If yes, packs/times per day? _____ Number of years _____

☐ Yes ☐ No Alcohol Type: ☐Beer ☐ Wine ☐ Liquor # of drinks per week _____ If yes, do you drink daily? ☐ Yes ☐ No

☐ Yes ☐ No Marijuana/Cocaine/Other Drug Use Type: _____ Frequency: _____

Family Medical History:

(List any family history for significant conditions such as Heart Disease, Hypertension/High Blood Pressure, Stroke, Diabetes, Cancer, Rheumatoid Arthritis, etc.)

Father: _____ Deceased ☐ Yes ☐ No

Mother: _____ Deceased ☐ Yes ☐ No

Sibling (s): _____ Deceased ☐ Yes ☐ No

Current Medications: (Please list prescription medications, over-the-counter medications, and vitamins)

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Review of Systems:

(Indicate any symptoms you have experiences in the last three months)

Constitutional

☐ Yes ☐ No Fever

☐ Yes ☐ No Chills

☐ Yes ☐ No Weight Loss

☐ Yes ☐ No Night Sweats

Respiratory

☐ Yes ☐ No Asthma

☐ Yes ☐ No Shortness of Breath

☐ Yes ☐ No Recent Cold/Flu

☐ Yes ☐ No Coughing up Blood

Neurological

☐ Yes ☐ No Headaches

☐ Yes ☐ No Numbness

☐ Yes ☐ No Weakness

☐ Yes ☐ No Seizures

☐ Yes ☐ No Vertigo/Dizziness

☐ Yes ☐ No Lack of Coordination

☐ Yes ☐ No Loss of Balance

☐ Yes ☐ No Stroke

Musculoskeletal

☐ Yes ☐ No Fracture/Broken Bone

☐ Yes ☐ No Joint Pain/Swelling

☐ Yes ☐ No Muscle Weakness

☐ Yes ☐ No Gout

☐ Yes ☐ No Arthritis

☐ Yes ☐ No Musculoskeletal Pain

Location? _____

Cardiovascular

☐ Yes ☐ No Chest Pain/Heart Attack

☐ Yes ☐ No History of Blood Clots

☐ Yes ☐ No Swelling of Ankles/Feet

☐ Yes ☐ No Poor Circulation

☐ Yes ☐ No Heart Palpitations

☐ Yes ☐ No High Blood Pressure

☐ Yes ☐ No Heart Disease

Gastrointestinal

☐ Yes ☐ No Indigestion

☐ Yes ☐ No No Ulcers

☐ Yes ☐ No Black/Bloody Stools

☐ Yes ☐ No Liver Disease/Hepatitis

Eyes

☐ Yes ☐ No Vision Loss

☐ Yes ☐ No Glasses/Contacts

☐ Yes ☐ No Other: _____

Skin

☐ Yes ☐ No Eczema/Psoriasis

☐ Yes ☐ No Rash

☐ Yes ☐ No Ulcer

Ears/Nose/Throat/Mouth

☐ Yes ☐ No Hearing Loss/Disorders

☐ Yes ☐ No Dentures

☐ Yes ☐ No Sore Throat

Endocrine

☐ Yes ☐ No Cold/Heat Intolerance

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Thyroid Disorder

Women Only

☐ Yes ☐ No Currently Pregnant

Genitourinary

☐ Yes ☐ No Painful Urination

☐ Yes ☐ No Blood in Urine

☐ Yes ☐ No Urinary Infection

☐ Yes ☐ No Decrease in Urine Flow

☐ Yes ☐ No Urgency to Urinate

Psychiatric

☐ Yes ☐ No Depression

☐ Yes ☐ No Anxiety

☐ Yes ☐ No Mental Illness

☐ Yes ☐ No Sleeping Disorder

☐ Yes ☐ No Memory Loss

Hematologic/Lymphatic

☐ Yes ☐ No Swollen Glands/Nodes

☐ Yes ☐ No Anemia

☐ Yes ☐ No Bleeding Disorder

☐ Yes ☐ No Blood Transfusion(s)

Allergy/Immunologic

☐ Yes ☐ No Exposure to Hepatitis

☐ Yes ☐ No Persistent infection

☐ Yes ☐ No Exposure to HIV

☐ Yes ☐ No Exposure to TB

Any Past Surgery and date:

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____

Patient Signature (Parent if minor) Date

_____ _____

Physician Signature Date

PAYMENT AND CREDIT POLICY

Thank you for selecting Synergy Specialist Medical Group for your health care needs. We have listed below our payment and credit policy for your convenience and understanding

PATIENT RESPONSIBILITY

Patients are responsible for all charges resulting from care with the provider. As a service to you we are contracted with most insurance companies and bill those carriers directly. Should insurance companies delay payment, you will need to participate in expediting payment. If certain procedures are not a covered benefit or considered not medically necessary by your insurance company, you will be required to sign an insurance waiver/disclaimer stating you understand the payment for such services is your responsibility. Patients need to understand that there are many insurance companies and different programs within those companies, that our staff cannot be expected to be "experts" on what is covered and what is not covered. The expectation of understanding one's plan falls on the shoulders of the patients. When in doubt a patient may call their insurance company's customer service number on the back of their card prior to an anticipated visit. This may not, however, eliminate the need to sign a waiver at the time of service. Patients who are unable to provide proof of insurance will be required to pay in full at the time of service. The undersigned will agree to be responsible for payment of any balances for care rendered to a minor. By signing this form you are certifying that you are eligible for benefits under your Health Plan. You understand if this is not correct or if you are not eligible under the terms of your Health Plan Agreement, you will assume responsibility for all charges for services rendered. In addition, if the above is not correct, you agree to pay in full for all services received within 30 days of receiving a bill from Synergy Specialist Medical Group.

PROOF OF INSURANCE

All patients must complete our Patient Information form before seeing the doctor. We must obtain a copy of your driver's license/photo ID and current valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Synergy Specialist Medical Group participates with Medicare and most PPO insurance plans. Please check with the staff to be sure your PPO or HMO is one we accept. We will bill any secondary insurance upon receipt of payment from the primary insurance. The patient will be required to sign a waiver agreeing to pay for any services not covered by their insurance.

INSURANCE AND PATIENT BILLING

New Patients —If you want Synergy Specialist Medical Group to bill your insurance, you are required to provide your insurance card for any primary and secondary plans at the time of your services. If you have no insurance, or do not want Synergy Specialist Medical Group to bill your insurance, you will be required to pay in full at time of service.

Established Patients —You will need to bring your current insurance card(s) to each visit so that Synergy Specialist Medical Group can verify current insurance information for billing the services you receive. Established patients are also required to complete an updated registration form and confirm billing information on an annual basis or at any time there is a change in the billing information. If you have no insurance, or do not want Synergy Specialist Medical Group to bill your insurance, you will be required to pay in full at time of service.

CO-PAYS AND DEDUCTIBLES

All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If co-pays that are not paid at time of service, resulting in a bill to the patient, a $25 billing charge will be assessed in addition to the co-pay. All charges not covered by insurance are due and payable within 30 days of the first billing you receive unless you have arranged a budget payment plan with our Billing Department.

A $50 fee will be assessed for each check or electronic transaction that is denied by your bank for any reason.

Personal balances over $200.00 will be required to make minimum payments of $50.00 per month. Patients with personal balances over 90 days who do have a payment plan with the Billing Department may be referred to collection agency.

APPOINTMENTS

A scheduled time has been reserved for you. Please give 24 hours notice if you are unable to keep this appointment. There may be a charge of $50.00 for NO SHOW office visit appointments or if office visit appointments are not cancelled a day in advance.

Scheduled in-office procedures that are not cancelled a day in advance may be subject to a charge of $50.00.

Scheduled surgical procedures that are not cancelled a day in advance may be subject to a charge of $100.00.

RECORDS/FORMS

If you request our staff or physicians to complete disability or FMLA forms there will be a fee of $25.00.

There is a $25 fee for any CD Copies of your medical records.

TO ALL OF OUR PATIENTS

Synergy Specialist Medical Group is committed to providing quality services to his patients. We have developed this payment/credit policy in an attempt to provide fair service to all of our patients while trying to keep health care costs down. We appreciate your assistance and understanding of our policy. Please remember, while we are billing your insurance for you, it is still your responsibility to follow-up with the insurance company and to make sure that there is timely payment of your account. If you have any questions, regarding your bill, please contact our office at: 858-571-9500.

I HAVE READ, UNDERSTAND, AND AGREE TO THE GUIDELINES OUTLINED IN THIS POLICY.

_____

Patient Name

_____

Signature

_____

Date

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

_____

_____

NOTICE OF PRIVACY PRACTICES

Synergy Specialist Medical Group / San Diego Musculoskeletal Institute
Tal S. David, M.D. / Christopher L. Sherman, D.O. / Jonathan J. Myer, M.D.
4910 Directors Place Suite 350 San Diego, CA 92121
Privacy Officer: Jeff Craven (858) 346-7171

Effective Date: October 25, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business

associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities, which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing.** Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in, We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any

financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **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.
19. **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.
20. **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.

21. **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 a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy**. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures**. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not

have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

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

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(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.

Release of Medical Records

I hereby authorize and request you to release to Synergy Specialist Medical Group the following records:

[ ] Complete records

[ ] X-rays

[ ] Arthrograms

[ ] Biopsy results

[ ] EMG Studies

[ ] Orthopedic related records

[ ] CAT & MRI scans

[ ] Nuclear Scans

[ ] Pathological slides

[ ] All of the above

Name_____

SS#_____ DOB_____

Address_____

City State Zip_____

Patient Signature_____ Date_____

Witness_____

HIPAA Right of Access Form for Family Member/Friend

I,_____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name	Relationship
Name	Relationship
Name	Relationship

Health Information to be disclosed upon the request of the person named above
(Check either A or B):
□A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR** □B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
□Mental health records □Communicable diseases (including HIV and AIDS)
□Alcohol/drug abuse treatment □Other (please specify):

_____
_____
_____
_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
□Direct Communication □An electronic record or access through an online portal
□Hard copy
□All of the Above

This authorization shall be effective until (Check one):
□Past, Present, and Future Episodes, OR:
□Date of the event:_____ unless I revoke it.
(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of the Individual Giving this Authorization	Date of Birth
Signature of the Individual Giving This Authorization	Date

TREATMENT WITHOUT PARENT/GUARDIAN CONSENT FORM

I, _____, give Synergy Specialist Medical Group permission to treat my child, _____, while I am not present.

Parental contact information for questions regarding treatment of the child:

Parent Name:_____

Parent Signature:_____ Date: _____

Contact Info:

Cell:_____ Home: _____ Work: _____

Email:_____

Mailing Address:_____

City _____State _____ Zip Code: _____