Vista Del Mar Medical Group, Inc.

"Your Personal Private Physician"

PRACTICE POLICIES

The following policies support the relationship between you, as the patient, and your physician. Please review and sign below to acknowledge that you have read and understand these policies.

Our practice serves patients with chronic to severe medical needs. If you have not been scheduled for a visit to one of our four offices within a period of two years, we may choose to dismiss you from the practice for habitual failure to comply with your physician's care.

Patients who regularly miss appointments cause other patients a delay in care or cause them to be seen at a later date or time. Due to the high risks associated with your medical care not being managed as your Vista Del Mar physician deems appropriate, we may dismiss you from the practice for persistent failure to keep appointments. To encourage all patients to attend their appointments, we charge a $50.00 no-show fee.

There are numerous health insurance companies, each offering many different plans. Even Medicare has multiple plan options. Our office does our best to understand the various insurance plans, however, we cannot guarantee to have knowledge of all plans that our patients may have. **Your best financial guarantee is to know your plan, the physicians on the panel, the approved diagnostic centers, and to fully understand your insurance deductibles, co-pays, or co-insurances.**

Our policy is to collect co-payments and co-insurance at the time of service. If you are unable to make a payment at the time of service, please contact our office prior to your appointment to make financial arrangements.

You will be responsible for informing us of any address, phone number, or insurance changes. Please confirm your information every time you visit our office to verify that your records are current.

Please remember to ask for a written prescription for all your medications during your office visit, as we are unable to refill prescriptions by phone, fax, or email.

We appreciate your support of these policies.

Practice Administrator

By signing below, I acknowledge that I have received a copy of and fully read and understood the Vista Del Mar Medical Group policies listed above.

Printed Name of Patient/Responsible Party	Date
Signature of Patient/Responsible Party	Relationship to Patient

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AUTHORIZATION FOR SHARING OF MEDICAL RECORD

Patient Name	Date of Birth
Home Address	SSN
City, State Zip Code	Phone Number

I authorize the release of my medical record to the following individual(s):

Name	Relationship
Name	Relationship
Name	Relationship

I hereby authorize disclosure of my health information to the people listed above and I will waive all statutory restrictions that might otherwise be applicable to this disclosure. I understand that I may cancel this request at any time with written notification, but it will not affect any information released prior to notification of cancellation. I understand that any personal health information disclosed by the individuals named above is not under the control of my physician and that my physician, or any Vista Del Mar Medical Group physician, is not responsible for disclosures made by the individuals named in this authorization.

Signature of Patient/Responsible Party	Date

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INSURANCE RELEASE

We are participating providers in many health plans, independent practice associations (IPAs), preferred provider organizations (PPOs), Medicare, and provide specialty services for many of the area's health maintenance organizations (HMOs) and CHAMPUS/TRICARE.

We will bill your Medicare insurance, and your private insurance should you have secondary coverage, for you at no charge to you.

If you belong to a preferred provider organization (PPO) or a health maintenance organization (HMO) with which we participate, we will bill this insurance for you in accordance with our contract.

You are responsible for all co-payments required by your insurance contract. Co-payments will be collected prior to your service.

It is also your responsibility to inform our practice of any changes in your health insurance. If we are not aware of any changes, you will be personally responsible for services rendered. Additionally, many of the health plans have prior authorization requirements, particularly if our physician is not named as your primary care provider.

If your insurance requires prior authorization for your visit, you will not be seen without prior authorization.

By signing below, I acknowledge that:

- **I have received a copy of and fully read and understood the Vista Del Mar Medical Group insurance release policies listed above**
- **I authorize payment of medical benefits to Vista Del Mar Medical Group**
- **I authorize payment of Medicare benefits to Vista Del Mar Medical Group**
- **I authorize the release of any medical information necessary, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), to process this claim**

Printed Name of Patient/Responsible Party	Date
Signature of Patient/Responsible Party	Relationship to Patient

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PRESCRIPTION DRUG RELEASE

While caring for you, part of your treatment plan may include prescription medicines that may contain risks or adverse reactions. Vista Del Mar Medical Group physicians consider all possible harmful effects and all possible successful outcomes from the use of these drugs. Our physicians will attempt to provide an explanation of the common side effects that you may experience, however, it may not encompass all possible complications. A copy of the prescription instructions and warnings given by the drug's manufacturer is available to you upon request.

By signing below, I acknowledge that I have fully read and understood the Vista Del Mar Medical Group prescription drug release policy listed above. Additionally, I release Vista Del Mar Medical Group, Inc. from any liability related to a lack of consent or informed consent pertaining to any prescription drug.

Printed Name of Patient/Responsible Party _____ Date _____

Signature of Patient/Responsible Party _____ Relationship to Patient _____

PRESCRIPTION REFILL POLICY

Physicians of Vista Del Mar Medical Group, Inc. are unable to refill medications over the phone. As of June 1993, this practice will not be taking prescription requests over the phone to ensure the patient's safety.

During each visit with your physician, please review all of your medications with him/her and ask for refills at that time. If you run out of medication before your next visit, you will be required to come into our office to meet with your physician or any other physician of Vista Del Mar Medical Group to obtain your refill.

By signing below, I acknowledge that I have received a copy of and fully read and understood the Vista Del Mar Medical Group prescription refill policy listed above.

Printed Name of Patient/Responsible Party _____ Date _____

Signature of Patient/Responsible Party _____ Relationship to Patient _____

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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. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this official note of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms and the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or healthcare operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish this task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided from each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment of services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence medication we prescribe for the treatment process.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, your insurance company, or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you from health care operation to ensure that you received quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records

- To workers' compensation or similar programs for processing claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMAITON REQUIRING YOUR WRITTEN AUTHORIZATION

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 authorization. If you give us authorization to use or disclose medical information about you, you make revoke that authorization, in writing at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMAITON

Complaints – If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Submit your complaint to one or both of the following addresses:

Attention: Privacy Officer
Vista Del Mar Medical Group, Inc.
1200 West Gonzales Road, Suite 300
Oxnard, California 93036
(805) 983-0691

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

OCRComplaint@hhs.gov

www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf

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 of health care operations or to someone

who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications – You have the right to request how we should send communication about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy – You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend – If you feel that 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. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not a part of the information which you would be permitted to inspect or copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have a right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Statements of disagreements and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures – You have the right to request a list of the disclosures we made of medical information about you. To request a list, you must submit your request to the Privacy Officer at the practice. Your request must state the time period for which you want to receive a list of disclosures that is not longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing this list.

Right to a Paper Copy of this Notice – You have the right to a paper copy of this Notice at any time. To obtain a paper copy of the current Notice, please request one and it shall be given to you.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as information we receive in the future. We will post a copy of the current Notice, with the effective date in the header of the first page.

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Acknowledgment of Receipt of Notice of Privacy Practices

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide you, the patient or personal representative, a copy of our Notice of Privacy Practices and for you to sign as acknowledging receipt of the document.

By signing below, I understand that Vista Del Mar Medical Group, Inc. ("VDMMG") may share my health information for treatment, billing, and healthcare operations. I have been provided a copy of VDMMG's Notice of Privacy Practices that describes how my health information is used and shared. I understand that VDMMG has the right to change this notice at any time. I acknowledge that I have received a copy of and fully read and understood the Vista Del Mar Medical Group Notice of Privacy Practices.

_____	_____
Printed Name (Patient/Parent or Legal Guardian)	Date
_____	_____
Signature (Patient/Parent or Legal Guardian)	Relationship to Patient

AUTHORIZATION TO LEAVE MESSAGES

I authorize Vista Del Mar Medical Group, Inc. to leave messages regarding my protected health information (PHI) on my telephone answering machine or with a family member or other designated party listed below:

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

INABILITY TO OBTAIN AKNOWLEDGEMENT (to be completed by office staff)

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

- □ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt
- □ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices
- □ Other: _____

_____	_____
Printed Name (Patient/Parent or Legal Guardian)	Date

_____

VDMMG Employee Signature

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OPEN PAYMENTS NOTICE

Starting January 1, 2023, pursuant to Assembly Bill 1278 (AB 1278), physicians are required to provide a notice to their patients regarding the Open Payments Database which is managed by the United States Centers for Medicare and Medicaid Services (CMS). The Open Payments Database is a federal search tool to research reported payments from applicable entities to covered recipients such as physicians. The purpose of the Open Payments Database is to promote transparency and accountability within healthcare systems.

For informational purposes only a link to the United States Centers for Medicare and Medicaid Services (CMS) Open Payments Database portal is provided below.

https://openpaymentsdata.cms.gov/

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

By signing below, I acknowledge that I have received a copy of and fully read and understood the Vista Del Mar Medical Group Open Payments Notice listed above.

Printed Name of Patient/Responsible Party	Date
Signature of Patient/Responsible Party	Relationship to Patient
VDMMG Staff Member Signature as Witness	Date

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HEALTH QUESTIONNAIRE

To best serve your medical needs, we ask that you thoroughly complete the following questionnaire as accurately as possible. The relationship between healthcare provider and patient is a privilege built on trust and honesty. By completing and signing this form, you understand that any false information may adversely affect your health.

Name: _____ Gender: ☐ Male

Date of Birth: _____ /_____ /_____ ☐Female

Race:
☐ American Indian/Alaskan Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian
☐ Other Race:
☐ Unknown
☐ Decline to Share

Ethnicity:
☐Hispanic/Latino
☐Not Hispanic/Latino
☐ Unknown
☐ Decline to Share

Marital Status: _____ Occupation: _____

If you have a personal history of the following, please circle all those that apply and explain if necessary:

		Explanation: _____
Hypertension	Diabetes	_____
Tuberculosis	Asthma	_____
Pneumonia	Heart Disease	_____
Heart Attack	Stroke	_____

If you have had any surgeries in the past, please list surgery type and approximate date(s):

Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____

Do you take any medications? Please list type of medication, dosage, and how you take it:

_____

_____

_____

Do you have any allergies? _____
Have you had any injuries? _____

_____

Do you smoke? _____ Packs per day: _____ How many years: _____
Do you drink? _____ Number/type per day: _____ How many years: _____
Drug use other than listed above? _____

Any recent weight changes? Please explain _____
Any recent fever? Please explain _____

Thank you for helping us best serve your healthcare needs

Childhood illnesses? Please circle all that apply:

Rheumatic Fever Scarlet Fever Diphtheria Polio Other:

Family History

Mother's age: _____ Any: diabetes, heart disease, or high blood pressure? Circle all that apply

Father's age: _____ Any: diabetes, heart disease, or high blood pressure? Circle all that apply

Brother(s)/Sister(s) ages and/or medical problems: _____

_____

_____

Have you **recently** had any of the following? Please circle Yes or No to each:

HEAD
Headaches Y N
Dizzy Spells Y N
Head Injuries Y N

NOSE
Bleeding Y N

LUNGS
Asthma Y N
Bronchitis Y N
Emphysema Y N
Cough Y N
Coughing up Blood Y N

STOMACH
Loss of Appetite Y N
Difficulty Swallowing Y N
Stomach Pain Y N
Ulcers Y N
Vomiting Y N
Vomiting Blood Y N
Gallbladder Problems Y N
Hepatitis Y N
Jaundice Y N
Constipation Y N
Diarrhea Y N
Hemorrhoids Y N
Change in Bowel Habits Y N
Hernias Y N

DERMATOLOGIC
Rash Y N
Suspicious Moles Y N

EYES
Double Vision Y N
Blurred Vision Y N
Glasses Y N
Cataracts Y N
Glaucoma Y N

MOUTH
Sores Y N
Dentures Y N

HEART
Chest Pain Y N
Palpitations Y N
Irregular Heartbeat Y N
Swollen Ankles Y N
Wake up with Shortness of Breath Y N
Shortness of Breath with Activity Y N

ENDOCRINE
Thyroid Problem Y N
Diabetes Y N
High Cholesterol Y N

GENITOURINARY
Nighttime Urination Y N
Pain with Urination Y N
Blood in Urine Y N
Bladder Infections Y N
Kidney Stones Y N
Trouble Starting Urine Y N
Loss of Bladder Control Y N
Prostate Problems Y N

HEMATOLOGIC
Transfusions Y N
Anemia Y N
Clotting Problems Y N

EARS
Hard of hearing Y N
Ringing in Ears Y N
Ear Infections Y N
Discharge Y N

NECK
Chronic Pain Y N

BREAST
Lumps Y N
Pain Y N
Discharge Y N

GYNECOLOGIC
Abnormal Bleeding Y N
Vaginal Discharge Y N
# of Pregnancies _____
# of Miscarriages _____

BONES & JOINTS
Painful/Swollen Joints Y N
Muscle Cramps Y N
Arthritis Y N
Gout Y N
Osteoporosis Y N
Back Pain Y N
Leg Cramps with Exercise Y N
Fingers Change Color in the Cold Y N

NEUROLOGIC
Seizures Y N
Blackouts Y N
Numbness Y N
Paralysis Y N

Patient Signature: _____ Date:_____