REGISTRATION FORM: *Please Print*

Complete ALL sections that apply to the patient.

Missing information may result in charges billed directly to the patient. **PATIENT INFORMATION – PAGE 1**

Last Name: First Name: M.I.:
Also known as or maiden name:
Marital Status: Single Married Date of Birth: Age:
Sex: M F Social Security #*:
Race/ Ethnicity: Black/ African American White/ Caucasian Native Hawaiian/ Other Pacific Islander Multiple Races American Indian/Alaska Native Asian Unknown Other or Prefer not to specify
Preferred Phone #: Home Cell Work
Second Phone#: Home Cell Work
Street Address: P.O. Box/ Apt#:
City: State: Zip Code:
E-mail Address:
Employer: Phone#:
Primary Care Physician: Phone#:
Did a Physician refer you to this Office or did you Choose this office yourself?: Physician Self
If a Physician, Please state who:
Preferred Pharmacy: Phone#:
Pharmacy Location/ Cross Streets:

INJURY INFORMATION

Non-Work Related Injury: Yes No If yes, please specify Date of Injury:
Work Related Injury: Yes No If yes, please specify Date of Injury:

IN CASE OF AN EMERGENCY

Emergency Contact: Relationship to Patient:
Home Phone#: Work Phone#:

Our electronic medical record system (EMR) requires your social security number as your unique identification number. Please help us provide you with the highest quality of care by sharing your social security number. This is very important because without your social security number as an identifier, your electronic medical record may not be compete or may contain inconsistencies. Please be confident your social security number is used only used for this purpose – it is never printed out. It is protected from misuse just as we protect your health information.

REGISTRATION FORM: *Please Print*

Complete ALL sections that apply to the patient.

Missing information may result in charges billed directly to the patient. **PATIENT INFORMATION – PAGE 2**

Last Name: First Name: M.I.:

INSURANCE INFORMATION – *Please give your insurance card to the receptionist.*

Guarantor Information: ***Check here if same as patient***

Responsible Party: Date of Birth:

Address *(if different form patient)*: Home Phone#:

Occupation: Employer:

Employer Address: Phone #:

PRIMARY INSURANCE – Insurance Company Name:

Subscriber's Name: Subscriber's SSN#:

Date of Birth: Group #: Policy #:

Co-Pay: $ Patient's relationship to subscriber: Self-01 Spouse-02 Child-03 Other:

SECONDARY INSURANCE *(IF APPLICABLE)* - Insurance Company Name:

Subscriber's Name: Subscriber's SSN#:

Date of Birth: Group #: Policy #:

Patient's relationship to subscriber: Self-01 Spouse-02 Child-03 Other:

Is this a worker's compensation claim: Yes No

Medicare Secondary Reason Code (Must check one if Medicare is Secondary):

12 **Working Aged** Beneficiary or Spouse with Employer Group Health Plan
13 End-Stage Rental Disease Beneficiary in the Mandated coordination Period with an Employer's Group Health Plan
14 No-fault Insurance including Auto is Primary
15 Worker's Compensation
16 Public Health Service (PHS) or Other Federal Agency (Government Research Program)
41 Black Lung
42 Veteran's Administration
43 **Disabled** Beneficiary Under Age 65 with Large Group Health Plan (LGHP-Employers with 50+ employees)
47 Other Liability Insurance is Primary (Homeowners)

PRIVACY CLAUSE: A person is liable for constructive invasion of privacy when they attempt to capture, any type of visual image, sound recording, or other physical impression of another individual engaging in a personal or familial activity under circumstance in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than $5,000 and not more than $50,000 [California Civil Code, Section 1708.8].

_____

Patient/ Guardian Signature Date

Financial and Billing Policies

Thank you for choosing **Dr. Kenty U Sian**. We are committed to clinical excellence in meeting your health care needs. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payment s and other provisions. If you have any questions, call your health plan's member services department. Their number is listed in your benefit plan booklet or on your ID card.

Inform us of changes: If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and payments.

Bring your health information: Bring your health insurance information to every visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly addition forms dependent on your visit.

Co Payments, Deductibles and Coinsurance: Co-pays are due at the time of your visit. Under the terms of our contract with the insurance plans, we cannot waive any amounts that are the patient's responsibility. If you have any questions regarding your copayments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, debit, VISA and MasterCard.

Deposits: For certain procedures not covered by insurance, you may be required to pay a deposit or pay for the service in full prior to treatment.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre-existing, or is not a covered service, you will be asked to pay prior to the time of service.

HMO/Managed Care Plans: It is your responsibility to make sure a current referral has been obtained for your care with our physician. If a referral has not been obtained by your appointment, you may need to reschedule your visit. We are sorry for the inconvenience, but without the proper referral, our physician will not be reimbursed for the service provided.

Workers Compensation: Please bring your claim number, date of injury, adjustor's name and phone, and employers/work compensation information. Your claim needs to be valid for your medical condition and the reason of your visit.

Patient Responsibility Balances: All patient balances are billed at the beginning of each month. Balances are due within 30 days. You will receive your statement once your insurance has paid their portion of the bill.

Confidentiality: Our Patient Account Representatives will only speak with the patient or the person designated in writing by the patient to receive the bills on behalf of the patient.

Thank you for reviewing our billing policies. All billing inquiries are handled by our billing staff. If you have questions, please call Tracy or one of her staff members at (559) 253-2802. Staff members are available and ready to help you, Monday through Friday from 8:30am to 4pm.

I have read, understand and agree to the above Billing Policies. I understand charges not covered by my insurance company, as well as applicable copayments and deductibles, are my financial responsibility.

I authorize my insurance benefits to be paid directly to **Kenty U Sian, MD Inc**. I authorize Dr. Sian to release medical information to my insurance company as necessary. I have given complete and accurate information and agree to inform Dr. Sian and his staff of any changes regarding my personal billing information or my insurance billing information.

_____ _____ _____

Date Signature Printed Name

No Show/Appointment Cancellation Policy

If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give your appointment to another patient. If you fail to keep your appointment or call 24 hours in advance, you will be charged $75.00 for a "no show" fee. This fee is not covered by insurance and will be your responsibility.

I have read, understand and agree to the above No Show/Appointment Cancellation Policy:

_____ _____ _____

Date Signature Printed Name

Agreement and Authorization for Services Consent Form

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to Fresno Plastic Surgery, I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the Fresno Plastic Surgery medical staff and personnel. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination.

II. Retention of Information

I understand that Fresno Plastic Surgery may record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by Fresno Plastic Surgery for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-Fresno Plastic Surgery personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

III. Release of Information

I hereby authorize Fresno Plastic Surgery to release to my insurance companies, employer insurance groups, health plans, Medicare program, its insurance carriers or intermediaries any medical records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by Fresno Plastic Surgery and the physicians associated with it. I may revoke my consent at any time for any reason by providing written notification to Fresno Plastic Surgery. This authorization shall not conflict with any internal Fresno Plastic Surgery policy regarding release of information which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal Law.

IV. Assignment of Benefits and Guarantee of Payment

In consideration of Fresno Plastic Surgery and medical services provided to me, I hereby assign Fresno Plastic Surgery and Dr. Kenty Sian all of my rights and claims for reimbursement under Medicare, group accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay Fresno Plastic Surgery and Dr. Kenty Sian the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.

Agreement and Authorization for Services Consent Form

I have read each of the foregoing, I-IV and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

Patient	Date
Guardian if patient is under 18 years old	Date
Other (record relationship to patient)	Date
Witness	Date

Acknowledgement of Receipt of Privacy Notice

I have received the Fresno Plastic Surgery Privacy Notice during this visit. I understand that I may obtain a copy of any future revised notices at the Fresno Plastic Surgery office.

_____ _____

Patient/Spouse/Nearest Relative/Legal Guardian Date

To be completed by Fresno Plastic Surgery staff if acknowledgement is not signed:

Reason that this acknowledgement was not signed:

_____ Patient indicates received on prior visit

_____ Patient declined to sign

_____ Other

_____ _____

Patient/Representative initials if declined Employee's initials

Personal Representative

In the space below, if so desired, please indicate any personal representatives*/individuals who are permitted to receive or know information concerning your healthcare for the period 12 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact Fresno Plastic Surgery in writing and request the change.

Name(s): _____

_____

_____ _____

Patient Signature Date

**A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is any family member, friend, or individual designated by the patient to whom the patient's health information may be disclosed.*

Shared Electronic Medical Records

We share an electronic medical records system with Practice Fusion.

Smoke Free Environment

For the health of our patients, employees and visitors, smoking is not permitted at Fresno Plastic Surgery.

Weapon Free Environment

Weapons of any kind are not allowed at Fresno Plastic Surgery.

No Show/Appointment Cancellation Policy

We would like to provide you with outstanding service. This however requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient. If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a "No Show" and a $75.00 charge may be billed directly to you since it is not covered by any insurance plan.

I have read, understand, and agree to the above No Show/Appointment Cancellation Policy.

_____ _____

Patient Signature (Guarantor if patient is a minor) Date

_____

Print Name

Electronic Appointment Reminders

We offer an appointment reminder and appointment change notification service via a text message to your cell phone (standard text message rates may apply).

_____ I want to receive appointment reminders and appointment change notifications via text message.

_____ I do not want to receive appointment reminders and appointment change notifications via text message.

_____ _____

Patient Signature Date

AUTHORIZATION FOR RELEASE
OF PATIENT PHOTOGRAPH

Name _____

Address _____
(street address, city, state and zip code)

I consent to the taking of photographs by **Dr. Sian** or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by **Dr. Sian**. I further authorize **Dr. Sian** or one of his/her associates to release to the **American Society of Plastic Surgeons ("ASPS")** such photographs.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from **Dr. Sian**.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge **Dr. Sian**, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature Date

NOTICE OF PRIVACY PRACTICES

Kenty U. Sian, M.D., F.A.C.S.
Cosmetic & Reconstructive Plastic Surgery

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.

If you have any questions about this notice or would like to request further information about our privacy policies and procedures, please contact the Privacy Officer, of our office at:

Kenty U. Sian, MD
1855 E. Alluvial Avenue, Suite 101
Fresno, CA 93720
(559) 797-0501

WHO WILL FOLLOW THIS NOTICE?

This notice describes information about our privacy practices followed by our employees, staff, office personnel, and other members of our workforce. The practices described in this notice will also be followed by all healthcare providers with whom you might consult with by telephone (when your regular healthcare provider from our office is not available) and by those who provide “call coverage” for your healthcare provider.

OUR RESPONSABILITIES AS REQUIRED BY LAW

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information. As part of our obligations, we shall notify affected individuals following a breach of unsecured protected health information. We have the right to change our Notice of Privacy Practices and we will apply the change to your entire health information, including information obtained prior to the change. We shall abide by the terms of the Notice of Privacy Practices currently in effect. We should post a notice of any changes to our Privacy Policy in our office lobby, on our practice website, and make a copy available to you upon request. In circumstances where state or federal law may further restrict the disclosure of your protected health information, we shall follow the more stringent law.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following describes different ways that we may use or disclose your protected health information. For each, we will explain what we mean and provide an example of such use or disclosure. Please be aware that not every use or disclosure in a particular category will be listed. Nevertheless, all of the ways in which we are permitted to use or disclose your protected health information will fall into one of the categories below.

For treatment. We may use protected health information about you to provide you with medical treatment or services. We may disclose protected health information about you to physicians, allied health professionals, technicians, trainees, volunteers, office staff, or other personnel who are involved in your healthcare.

For example, your physician may be treating you for a heart condition and may need to know if you have any other health problems that could complicate your treatment. The physician may use your medical history to decide what treatment is best for you. The physician may also tell another physician about your condition so that physician can help determine the most appropriate care for you.

Different personnel in our office may share protected health information about you and disclose protected health information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For payment. We may use and disclose protected health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations. We may use and disclosed protected health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your protected health information to evaluate the performance of our staff in caring for you. We may also use protected health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives. We may tell you about or recommended possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services. We may tell you about Health-Related Products or services that may be of interest to you.

Central California Health Information Exchange. We participate in the Central California Health Information Exchange (the "Exchange"), which is an electronic health record that is shared with other healthcare providers who participate in the Exchange and, in other certain limited circumstances, with other healthcare providers who are not Exchange participants, such as a specialist to whom you have been referred. Your electronic health record may also be available electronically for healthcare providers to access when it is determined that you require emergent care. You may opt-out of having your health information shared through the Central California Health Information Exchange.

SPECIAL SITUATIONS

We may use or disclose protected health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health 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 would only be to someone able to help or prevent the threat.

Required by Law. We will disclose protected health information about you when required to do so by federal, state, or local law,

Research. For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process. This process may include asking for your authorization.

Organ and Tissue Donation. If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence. If you are or were a member of the arm forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release protected health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' compensation. We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risk. We may release protected health information about you for public health reasons in order to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to

medications, or problems with products; or 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.

Health Oversight Activities. We may release protected health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. This disclosure may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits or Disputes. If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose protected health information about you in response to a subpoena.

Directory Information. We may disclose limited information regarding your name and location for directory purposes to those persons who ask for you by name or to member of the clergy. You may request that we not include your name in the directory.

Vaccine Registry. We may use and disclose vaccine information about you or your child to help maintain a regional registry that will assist counties with maintaining continuity and coordination of services.

Law Enforcement. We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar processes, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors. We may disclose protected health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their require duties, and 3) procurement organizations for purposes of organ and tissue donations.

Information Not Individually Identifiable. We may use or disclose protected health information about you in a way that does not individually identify you or that has been de-identified in accordance with applicable federal and state laws and regulations.

Fundraising and Marketing. We may contact you with information as part of our fundraising efforts, but you have a right to opt-out of receiving such communication.

Business Associates. There are some services provides to our organization through contracts with business associates, such as billing or transcription services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information in a manner consistent with applicable federal and state laws and regulations.

Family and Friends. We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose protected health information to your family or friends if we ca infer from

the circumstances, based on professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your protected health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are no capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose protected health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

DISCLOSURE REQUIRING AUTHORIZATION

We will not use or disclose protected health information for any purpose other than those identified in the previous sections without your specific, written Authorization. The following uses and disclosures will be made only with your authorization: 1) most uses and disclosures of psychotherapy notes, if recorded by a cover entity; 2) uses and disclosures of protected health information for marketing purposes; 3) disclosures that constitute a sale of protected health information; and 4) other uses and disclosures not described on this Notice of Privacy Practices.

If we have highly protected health information, such as, HIV, substance abuse, or mental health information about you, we cannot release that information without a special signed, written authorization (different from the authorization mentioned above) from you (i.e. you must specify the type of sensitive information we are allowed to disclose).

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the rights regarding protected health information we maintain about you:

Right to Inspect a Copy. You have the right to inspect and copy your protected health information that we use to make decisions about your care. Usually these include medical and billing records, but not psychotherapy notes and information complied for legal proceedings. You must submit a written request to the Privacy Officer, in order to inspect and/or copy your protected health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe the protected health 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 as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer. We will respond to your request for an accounting of disclosures within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay. We may deny for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that 1) we did not create, unless the person or entity that created the information is no longer available to make the amendment; 2) it is not part of the health information that we keep; 3) you will not be permitted to inspect and copy; or 4) is accurate and complete.

Right to an Accounting of Disclosure. You have the right to request an "accounting of disclosure". This is a list of the disclosures we made of protected health information about you, except those disclosures made for: 1) treatment, payment, or healthcare operations; 2) pursuant to a valid authorization; and 3) as otherwise provided in applicable federal and state laws and regulations. To obtain this "accounting of Disclosure", you must submit your request in writing to the privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting in any twelve (12) moth period is free of charge. Additional requests for accounting of disclosures may result in charges to you for the cost of providing such accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will respond to your request for an accounting of disclosure within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as o the reason for the delay.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. If you have paid for services out-of-pocket, in full, and request that we not disclose your protected health information, related solely to those services, to your health plan, we shall accommodate your request except where the disclosure is required by law.

You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose about a surgery you had. We are not required to agree to your request.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to the Privacy Officer.

Right to Request Confidential Communication. You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. For example, you can ask that we only contact you at work or only contact you by mail at a specifically identified address. Notwithstanding the foregoing, we will typically communicate with you in person; or by letter, email, fax, and/or telephone.

To request confidential communications, you may complete and submit the Request for Registration on Use/Disclosure of Medical information and/or Confidential Communication to the Privacy Officer. 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.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Privacy Officer.

Right to Revoke Authorization. You have the right to revoke an authorization to use or disclose your protected health information at any time, except where action has already been taken.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer at the address and telephone number listed on the first page of this notice. You will not be retaliated against or penalized for filing a complaint.

The contact information for the Secretary of Health and Human Services is:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 1-877-696-6775

Dr. Sian complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.