CUCAMONGA VALLEY™ MEDICAL GROUP

Welcome Contract

Welcome to Cucamonga Valley Medical Group!

We are pleased that you have chosen our medical group for your primary health care needs. In order to make your experience the best possible, we have implemented the following policies. Please read them carefully:

1. Appointments and scheduling

a) **Late appointments:** Your appointment may be rescheduled if you arrive more than 15 minutes late.
b) **First time visit:** Please arrive 30 minutes before the appointment time to complete insurance verification and the orientation process. If you have not completed your documents before your scheduled appointment time, we reserve the right to reschedule your appointment.
c) **Cancellation policy/ Missed appointments:** A $50 "No Show" fee will be charged to you *(this cannot be billed to insurance)* if you miss an appointment, or do not call to cancel your appointment 48 hours prior to your appointment time. This enables us to open up your time slot to another patient that is waiting to be seen.
d) **Same Day appointments:** Our best efforts will be made to accommodate same day appointments. Please call the office for availability prior to arrival.
e) **Appointment requirements:** In order to optimize your appointment time, please bring the following items to every visit:

i.All medications **ii.**Immunization record
iii. Insurance card **iv.**Any necessary paperwork that you need completed *(see paperwork policy below)*

2.Financial policies

a) **Co-pay and patient share payments:** Payments are required to be made in full at the time of the office visit. We accept cash, Visa, Mastercard, Discover and American Express. We do not accept checks of any kind.
b) **Insurance billing:** We will bill your insurance on your behalf if given all the proper information. Please note that you are ultimately responsible, however, for all charges incurred.
c) **Paperwork fee:** A $25 fee will be applied to all paperwork requested for the physician to complete, including disability forms, FMLA forms, jury excuses, etc.
d) **Medical Records fee:** A $35 medical record copying fee will be charged for medical records greater than 10 pages.

3.Laboratory results

It is important to us that you receive prompt notification of lab and test results, as well as a thorough explanation of the results.

a) **Pap smear results:** If you have a normal pap smear, a postcard will be sent to you to inform you of the results. If the result is abnormal, you will be notified by phone to make a follow-up appointment, or with other further instructions.
b) **All other laboratory tests:** Even if your lab results are normal, we ask that you make an appointment to discuss the results with your doctor. In many cases, despite normal results, there will be further recommendations. *(This follow up appointment will be treated as a regular office visit, and all applicable charges and co-pays will apply.)*
c) **No results received:** If you do not receive a letter or a call, do not assume that the results are normal. Please call our office so that we can follow up on the results.

4.After hours policy

We have a physician on call 24 hours a day, 7 days a week. If you have an urgent medical issue, and need to speak with the doctor after hours, you may call our office and leave a message to page the physcian on call. Please do not page the doctor for non-urgent medical issues, such as canceling or rescheduling appointments, medication refills or results inquiries. ***(Please note that if it is a life threatening medical problem, call 911.)***

5.Medication refills

a) We will not refill any narcotic or controlled medications after hours or over the phone. Ask your doctor for sufficient refills at the time of your visit to last until your next appointment *(typically 3–6 months)*. Please check with your pharmacy to see if you have any refills already approved before calling the office.
b) If you are on any chronic medications, your doctor will, in most cases, want to see you every 3-6 months to monitor the medications and their efficacy in treating your condition. It is for this reason that, if you have not been in to see the doctor in several months, that the refill may be denied.
c) We are pleased to announce that we now support the Sure Scripts service for electronic prescriptions. If your pharmacy uses this service, and you need a refill, please call your pharmacy and they will contact the office for refill authorization on your behalf.

I, _____,
PATIENT, PARENT OR GUARDIAN (PRINTED)

have read and received a copy of Cucamonga Valley Medical Group's policies.

_____ _____
SIGNATURE OF PATIENT *(PARENT OR GUARDIAN IF PATIENT IS A MINOR)* | DATE *(MM/DD/YY)*

CUCAMONGA VALLEY™ MEDICAL GROUP

Patient Registration

Welcome to Cucamonga Valley Medical Group. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Information

PATIENT'S FIRST AND LAST NAME | M.I. | TODAY'S DATE | D.O.B. | AGE

PARENT'S FIRST AND LAST NAME *(IF PATIENT IS A MINOR)* | PATIENT'S RACE | GENDER

PATIENT'S SOCIAL SECURITY NUMBER | PATIENT'S DRIVER'S LICENSE NUMBER | PATIENT'S MARITAL STATUS

HOME ADDRESS | CITY | STATE | ZIP CODE

MAILING ADDRESS *(WRITE "SAME" IF SAME AS HOME)* | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | WORK PHONE *(WITH EXT. IF APPLICABLE)*

E-MAIL ADDRESS | OCCUPATION | EMPLOYER *(OR SCHOOL IF FULL-TIME STUDENT)*

EMPLOYER'S ADDRESS *(SCHOOL ADDRESS IF FULL-TIME STUDENT)* | CITY | STATE | ZIP CODE

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Emergency Contact Information: *Who We Should Notify in Case of Emergency*

PRIMARY CONTACT'S FIRST AND LAST NAME | MIDDLE INITIAL | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | WORK PHONE *(WITH EXT. IF APPLICABLE)*

Guarantor Information: *Person Responsible For Fees / Insured Party / Legal Guardian*

FIRST AND LAST NAME | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | CELL PHONE | WORK PHONE *(WITH EXT. IF APPLICABLE)*

INSURANCE COMPANY | CLAIM ADDRESS

SUBSCRIBER'S NAME | D.O.B. | SUBSCRIBER'S SSN | INSURANCE ID NO.

SECONDARY INSURANCE COMPANY | CLAIM ADDRESS

SUBSCRIBER'S NAME | D.O.B. | SUBSCRIBER'S SSN | INSURANCE ID NO.

WERE YOU INJURED ON THE JOB? Y ☐ N ☐ *HAVE YOU INFORMED YOUR EMPLOYER?* Y ☐ N ☐

CUCAMONGA VALLEY™
MEDICAL GROUP

Expectation of Professional Patient Conduct

Cucamonga Valley Medical Group (CVMG) is a family practice and as such strives to ensure a safe, family-friendly environment. Above and beyond that, om staff and providers aim to live by our Core Culture, of which the main tenets are Life, Love, and Compassion. In order to foster that, we have carefully developed this policy.

We understand that it can be stressful for patients when there are long waits, if you are feeling unwell, or encountering a multitude of other life circwnstances, but we have a zero tolerance policy towards aggressive behavior and rudeness to our staff. We expect that you treat our staff, fellow patients, caregivers, and visitors politely and with respect. Violence or verbal harassment will not be tolerated or accepted under any circumstances. You may be asked to seek care at another primary care practice if this behavior occurs.

Types of behavior that are unacceptable include, but are not limited to:

Physical Assault	Negative, Spiteful,	Acting or appearing to be under the
Offensive Language	and Stereotypical Comments	influence of any substance that impairs
Verbal Abuse	Wielding of Objects/ Weapons	judgment
Swearing	Attempting Physical Abuse -	Bullying, Victimization, and Intimidation
Shouting and Intrusive Behavior	Threats of Injury	Stalking- 'lhreatening Behavior
Abusive Remarks	Offensive Gestures	Towards Staff and/or Their Family
Invasion of Personal Space	Damage to the Property	Members Outside of the Workplace

If you are considered to have breached this policy, one or more of the following may occur depending on the circumstances:

Discussion of behavior with Management	Discharged from our practice's care	Removal from the Practice
	Reported to the Police	

A good patient-doctor relationship, based on mutual respect and trust, is the cornerstone of good patient care. The removal of patients from our practices is an exceptional and rare event and is a last resort in an impaired patient-practice relationship. When trust has been irreversibly broken, it is in the patients best interest to find a new practice and we will facilitate this to our best ability (with the exception of violence, in which case the correct law enforcement authority will be requested to intervene).

PRINT PATIENT NAME

DOB:

SIGNATURE OF PATIENT (IF PATIENT IS A MINOR, SIGNATURE OF GUARDIAN)

Date:

CUCAMONGA VALLEY™ MEDICAL GROUP

Health History

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible.

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MIDDLE INITIAL | BIRTH DATE | M ☐ F ☐ GENDER

PRESENTING PROBLEM

Illness / Injury: (Please check if you have ever had)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Ulcers
- ☐ Heart Attack
- ☐ Heart Problems (Please List)
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Cancer (Please List Type)
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Blood Transfusion
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Thyroid Problem
- ☐ Lung Problems/Asthma
- ☐ Gallstones
- ☐ Exposure To Tuberculosis
- ☐ Other (Please List)

PLEASE LIST DETAILS OF ABOVE SELECTIONS, IF ANY

Family History: (Please check if an immediate family member– parents or siblings, has ever had)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer (Please List Type)
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Problems (Please List)
- ☐ High Cholestero
- ☐ Other (Please List)

PLEASE LIST DETAILS OF ABOVE SELECTIONS, IF ANY

Operations/Surgeries: (Please list names and dates of all operations you have had)

☐ NONE

NAME OF OPERATION | YEAR | COMPLICATIONS

NAME OF OPERATION | YEAR | COMPLICATIONS

NAME OF OPERATION | YEAR | COMPLICATIONS

Medications: (Please list all medications and dosages, including over-the-counter and supplements)

☐ NONE

NAME OF MEDICATION | DOSAGE AND FREQUENCY | NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY | NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY | NAME OF MEDICATION | DOSAGE AND FREQUENCY

Allergies: (Please list any medication allergies and reaction)

☐ NONE

NAME OF MEDICATION | REACTION | NAME OF MEDICATION | REACTION

NAME OF MEDICATION | REACTION | NAME OF MEDICATION | REACTION

CUCAMONGA VALLEY™ MEDICAL GROUP

Health History

Other Information:

Do you now use tobacco? ☐ Yes ☐ No
TYPE | AMOUNT / DAY | NO. YEARS

Have you ever used tobacco? ☐ Yes ☐ No
QUIT DATE

Do you drink alcohol? ☐ Yes ☐ No
TYPE | AMOUNT / DAY | NO. YEARS

Have you ever used alcohol? ☐ Yes ☐ No
QUIT DATE

Do you use street drugs? ☐ Yes ☐ No
TYPE | ☐ Yes ☐ No INTRAVENOUS | NO. YEARS

Have you ever used street drugs? ☐ Yes ☐ No
QUIT DATE | TYPE | ☐ Yes ☐ No INTRAVENOUS

Do you have an Advance Directive for Health Care? ☐ Yes ☐ No | Would you like more info on Advance Directives? ☐ Yes ☐ No

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

Date:

CUCAMONGA VALLEY™
MEDICAL GROUP

Terms and Conditions for Treatment

Financial Policy

Basic Policy Pay for service is due in full at the time service is provided in our office. You will be subject to a $35.00 fee for any returned check.

For Patients With Insurance We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you, and you may be subject to a $5.00 reprocessing fee.

Medicare Patients We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

Noncovered Services Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Personal Injury Cases This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

Assignment of Insurance Benefits *(Patients with insurances please read and sign below.)*

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Cucamonga Valley Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical or other information necessary to secure the payment.

PATIENT'S FIRST AND LAST NAME *(PLEASE PRINT)*

DATE OF BIRTH

SIGNATURE OF PATIENT (*PARENT OR GUARDIAN IF PATIENT IS A MINOR)*

DATE

Medicare Patients ONLY: Signature on File *(Skip Brown Box if You Do Not Have Medicare.)*

I request payment of authorized Medicare benefits be made either to me or on my behalf to Cucamonga Valley Medical Group, Inc. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S FIRST AND LAST NAME *(PLEASE PRINT)*

PATIENT'S MEDICARE NO.

SIGNATURE OF PATIENT

DATE

Cucamonga Valley Medical Group

PROVIDER

CUCAMONGA VALLEY™
MEDICAL GROUP

Terms and Conditions for Treatment

Consent to Medical Treatment:

I consent to the procedures which may be performed during office visits, including but not limited to medical or surgical treatment or procedures, x-ray examinations, laboratory procedures or anesthesia rendered under the care of the treating physician.

I have read, understood, and agreed to the above financial policy for payment of professional fees, and consent to medical treatment. **The patient is ultimately responsible for all professional fees.**

PATIENT'S FIRST AND LAST NAME *(PLEASE PRINT)*

PATIENT'S BIRTH DATE

SIGNATURE OF PATIENT *(PARENT OR GUARDIAN IF PATIENT IS A MINOR)*

DATE

CUCAMONGA VALLEY™ MEDICAL GROUP

Financial Responsibilities for Outside Services

Financial Responsibilities for Outside Services

You may receive a bill from a specialist office or laboratory if any tests or examinations are sent out or conducted outside of this office. Please be advised that any office visits, laboratory fees, and / or bills that you may receive are your responsibility.

If your insurance does not cover particular laboratory tests, examinations, or requires that you use a specific laboratory or physician(s), for such procedures, it is your responsibility to inform this office. Please contact your insurance carrier if you do not know what is covered by your policy.

Please sign below to acknowledge receipt of this notice.

PRINT PATIENT'S FIRST AND LAST NAME

DATE OF BIRTH

SIGNATURE OF PATIENT
(PARENT OR GUARDIAN IF PATIENT IS A MINOR)

DATE
(MM/DD/YY)

DATE OF RECIEPT

Acknowledgement of Receipt of Notice of Privacy Practices (NOPP)

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT AND AUTHORIZATION. IN REFUSING WE **MAY NOT BE ALLOWED** TO PROCESS YOUR INSURANCE CLAIMS.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS / FACILITIES IN THE FUTURE.**

PRINT PATIENT'S FIRST AND LAST NAME

SIGNATURE OF PATIENT
(PARENT OR GUARDIAN IF PATIENT IS A MINOR)

LEGAL REPRESENTATIVE

DESCRIPTION OF AUTHORITY

YOUR COMMENTS REGARDING ACKNOWLEDGEMENTS OR CONSENTS:

I approve being contacted about special services, events, fund raising efforts or new health information on behalf of this healthcare facility via:

☐ PHONE MESSAGE ☐ TEXT MESSAGE ☐ EMAIL ☐ ANY OF THE ABOVE ☐ NONE OF THE ABOVE (OPT OUT)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

CUCAMONGA VALLEY™ MEDICAL GROUP

Controlled Medication Agreement

Purpose: To ensure the safe, legal, and effective use of controlled substances in accordance with Cucamonga Valley Medical Group's (CVMG) policy and in compliance with California state laws and federal regulations.

Controlled Substances Covered: This agreement applies to all controlled substances prescribed by CVMG providers, including but not limited to:

- **Opioids:** Ultram (Tramadol), Vicodin/Norco (Hydrocodone), Percocet (Oxycodone), Tylenol #3/#4 (Acetaminophen with Codeine), Methadone, MS Contin (Morphine Sulfate)
- **Benzodiazepines:** Xanax (Alprazolam), Ativan (Lorazepam), Restoril (Temazepam)
- **Sleep Aids:** Ambien (Zolpidem)
- **Muscle Relaxants:** Soma (Carisoprodol)
- **Stimulants:** All prescription ADD/ADHD treatments
- **Anticonvulsants:** Lyrica (Pregabalin)

Agreement Terms:

1. **Office Visits and Prescription Management**
    - Controlled substances must be filled in person with an office visit at least once every six months.
    - Follow-up appointments via telehealth or in-office are required every 3 months, and in-office visits are required every six months for ongoing prescriptions.
    - Refill requests for controlled substances over the phone are only allowed between scheduled in-office visits, which are required every six months, and telehealth visits, which must be conducted at least every three months.
    - Providers will check the CURES database every time a controlled substance is prescribed.
2. **Refills and Prescription Policies:**
    - Generally, there will be no early refills of medications under any circumstances.
    - No refills will be provided for lost, stolen, or accidentally disposed medications.
        - Lost Medications
            - The medication bottle is misplaced during travel or while moving between locations.
            - The patient forgets where they placed the medication and cannot find it.
            - The medication falls out of a bag or pocket and is irretrievable.
        - Stolen Medications
            - The medication is stolen from the patient's home during a break-in.
            - A visitor or someone in the household takes the medication without the patient's knowledge or consent.
            - The medication is stolen from a car or bag while the patient is away from home.
        - Accidentally Disposed of Medications
            - The medication is accidentally thrown away with trash or recycling.
            - A pet or child accidentally spills or ingests the medication, rendering it unusable.

CUCAMONGA VALLEY™ MEDICAL GROUP

Controlled Medication Agreement

- The medication is flushed down the toilet or sink by mistake.
  - Medications will not be refilled if required labs, consults, or follow-up appointments are not completed.
  - Prescriptions will only be filled during normal office hours. No prescriptions will be filled after office hours or on weekends.

3. **Urine Drug Screens (UDS):**
   - A urine drug screen is required in-office at least once every six months.
   - If illegal substances or prescription medications not prescribed directly to you are found in the UDS, or if you refuse to undergo UDS, refills will not be provided, and your treatment plan may be reassessed.
4. **Patient Responsibilities:**
   - You must not receive controlled substance prescriptions from multiple providers or use multiple pharmacies. Doing so will be grounds for dismissal from CVMG.
   - You must sign this Controlled Substance Agreement annually.
   - You are responsible for ensuring safe use, storage, and disposal of your medications to prevent misuse or accidental exposure.
5. **Medication Tapering:**
   - If it becomes necessary to discontinue your medication, your provider will taper the dosage gradually rather than stopping it abruptly, to avoid withdrawal symptoms and other complications.
   - This tapering process will apply even if you default on this Controlled Medication Agreement.
6. **Dismissal Criteria:**
   - Violating this agreement, including refusal to sign, refusing regular UDS, or consistent requests for early refills, may result in the discontinuation of your controlled substance prescription and potential dismissal from CVMG.
   - Any inappropriate behavior toward providers or staff regarding the refill of these medications will also be grounds for dismissal.

Acknowledgment:

By signing below, you acknowledge that you have read, understand, and agree to comply with the terms of this Controlled Medication Agreement. Failure to comply may result in discontinuation of your controlled substance prescriptions and/or dismissal from Cucamonga Valley Medical Group.

Print Name of Patient: _____ **DOB:** _____
Signature of Patient: _____ **Date:** _____

If Patient is a Minor, Signature of Guardian: _____
Signature of Provider: _____
Date: _____

CUCAMONGA VALLEY™ MEDICAL GROUP

Notice of Privacy Practices (NOPP) for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DIS- CLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Under the HIPAA Omnibus Rule of 2013.

PLEASE REVIEW IT CAREFULLY

For purposes of this Notice "us" "we" and "our" refers to the Name of this Healthcare Facility: Cucamonga Valley Medical Group and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive healthcare services from us, we will obtain access to your medical information (i.e. your health history). We are committed to maintaining the privacy of your health information and we have implemented nu- merous procedures to ensure that we do so.

The Federal Health Insurance Portability & Ac- countability Act of 2013, HIPAA Omnibus Rule, (formally HIPAA 1996 & HI TECH of 2004) require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us in any form, whether electronic, on paper, or spoken. HIPAA is a Federal Law that gives you significant new rights to understand and control how your health information is used. Federal HIPAA Omni- bus Rule and state law provide penalties for covered entities, business associates, and their subcontrac- tors and records owners, respectively that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to pro- vide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for healthcare services. If you have any questions about this Notice, please ask to speak to our HIPAA Privacy Officer.

Our Rules on How We May Use and Disclose Your Protected Health Information

Healthcare Treatment, Payment and Operations Rule

Our doctors, clinical staff, employees, Business Associates (outside contractors we hire), their sub- contractors and other involved parties follow the policies and procedures set forth in this Notice. If at this facility, your primary caretaker / doctor is unavailable to assist you (i.e. illness, on-call coverage, vacation, etc.), we may provide you with the name of another healthcare provider outside our practice for you to consult with. If we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledge- ment of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign an Authorization / Acknowledge- ment form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your autho- rization / acknowledgement in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization / acknowledgment to provide services before you revoked it).

General Rule – If you do not sign our autho- rization / acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization/ acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/ acknowledgement or revoke it. With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate healthcare treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other healthcare providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or

another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment; Remember, you will be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under this new Omnibus Rule.

- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, (we will cover your name just after checking you in), we may tell you about or recommend health related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our Privacy Officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.
- Our doctors, clinical staff, employees, Business Associates (outside contractors we hire), their subcontractors and other involved parties follow the policies and procedures set forth in this Notice. If at this facility, your primary caretaker / doctor is unavailable to assist you (i.e. illness, oncall coverage, vacation, etc.), we may provide you with the name of another healthcare provider outside our practice for you to consult with. If we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledgement of this Notice, before we will use or disclose your PHI for certain purposes as detailed in the rules below.

CUCAMONGA VALLEY™ MEDICAL GROUP

Notice of Privacy Practices (NOPP) for Protected Health Information

Additionally you should be made aware of these protection laws on your behalf, under the new HIPAA Omnibus Rule:

- That **Health Insurance Plans** that underwrite cannot use or disclose genetic information for underwriting purposes (this excludes certain longterm care plans). Health plans that post their NOPPs on their web sites must post these Omnibus Rule changes on their sites by the effective date of the Omnibus Rule, as well as notify you by US Mail by the Omnibus Rules effective date. Plans that do not post their NOPPs on their Web sites must provide you information about Omnibus Rule changes within 60 days of these federal revisions.
- **Psychotherapy Notes** maintained by a healthcare provider, must state in their NOPPs that they can allow "use and disclosure" of such notes only with your written authorization.

Special Rules

Notwithstanding anything else contained in this Notice, only in accordance with applicable HIPAA Omnibus Rule, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or local law
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting information such as adverse reactions to anesthesia, ineffective or dangerous medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government healthcare oversight activities (i.e. civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.)
- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
- For Worker's Compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a workrelated injury or illness)
- For intelligence, counterintelligence or other national security purposes (i.e. Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)
- To create a collection of information that is "deidentified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others, but only if you are present and verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (i.e. you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed. **As per HIPAA law 164.512(j) (i)... (A) Is necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public and (B) Is to person or persons reasonably able to prevent or lessen that threat.**

Minimum Necessary Rule

Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the

claim form for the latest visit; janitorial staff will not access your PHI). All of our team members are trained in HIPAA Privacy rules and sign strict Confidentiality Contracts with regards to protecting and keeping private your PHI. So do our Business Associates and their Subcontractors. Know that your PHI is protected several layers deep with regards to our business relations. Also, we disclose to others outside our staff, only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. Still in certain cases, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a Consent or Authorization to receive a copy of your records
- To healthcare providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
- To the U.S. Department of Health and Human Services (i.e. in connection with a HIPAA complaint)
- To others as required under federal or state law
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with HIPAA law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For nonroutine requests or disclosures, our Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure

- Whether the same result could be achieved with de-identified information
- The technology available to protect confidentiality of the information
- The cost to implement administrative, technical and security procedures to protect confidentiality

If we believe that a request from others for disclosure of your entire medical record is unnecessary, we will ask the requestor to document why this is needed, retain that documentation and make it available to you upon request.

Incidental Disclosure Rule

We will take reasonable administrative, technical and security safeguards to ensure the privacy of your PHI when we use or disclose it (i.e. we shred all paper containing PHI, require employees to speak with privacy precautions when discussing PHI with you, we use computer passwords and change them periodically (i.e. when an employee leaves us), we use firewall and router protection to the federal standard, we back up our PHI data offsite and encrypted to federal standard, we do not allow unauthorized access to areas where PHI is stored or filed and/or we have any unsupervised business associates sign Business Associate Confidentiality Agreements).

However, in the event that there is a breach in protecting your PHI, we will follow Federal Guide Lines to HIPAA Omnibus Rule Standard to first evaluate the breach situation using the Omnibus Rule, 4-Factor Formula for Breach Assessment. Then we will document the situation, retain copies of the situation on file, and report all breaches (other than low probability as prescribed by the Omnibus Rule) to the US Department of Health and Human Services at:

http://www.hhs.gov/ocr/privacy/hipaa/administrative/ breachnotification-rule/brinstruction.html

We will also make proper notification to you and any other parties of significance as required by HIPAA Law.

Business Associate Rule

Business Associates are defined as: an entity, (non- employee) that in the course of their work will directly / indirectly use, transmit, view, transport, hear, interpret, process or offer PHI for this Facility.

Business Associates and other third parties (if any) that receive your PHI from us will be prohibited from redisclosing it unless required to do so by law or you give prior express written consent to the redisclosure. Nothing in our Business Associate agreement will allow our Business Associate to violate this redisclosure prohibition. Under Omnibus Rule, Business Associates will sign a strict confidentiality agreement binding them to keep your PHI protected and report any compromise of such information to us, you and the United States Department of Health and Human Services, as well as other required entities. Our Business Associates will also follow Omnibus Rule and have any of their Subcontractors that may directly or indirectly have contact with your PHI, sign Confidentiality Agreements to Federal Omnibus Standard.

Super-Confidential Information Rule

If we have PHI about you regarding communicable diseases, disease testing, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records (super-confidential information under the law), we will not disclose it under the General or Healthcare Treatment, Payment and Operations Rules (see above) without your first signing and properly completing our Consent form (i.e. you specifically must initial the type of super-confidential information we are allowed to disclose). If you do not specifically authorize disclosure by initialing the super-confidential information, we will not disclose it unless authorized under the Special Rules (see above) (i.e. we are required by law to disclose it). If we disclose super-confidential information (either because you have initialed the consent form or the Special Rules authorizing us to do so), we will comply with state and federal law that requires us to warn the recipient in writing that re-disclosure is prohibited.

Changes to Privacy Policies Rule

[We reserve the right to change our privacy practices (by changing the terms of this Notice) at any time as authorized by law. The changes will be effective immediately upon us making them. They will apply to all PHI we create or receive in the future, as well as to all PHI created or received by us in the past (i.e. to PHI about you that we had before the changes took effect). If we make changes, we will post the changed Notice, along with its effective date, in our office and on our website. Also, upon request, you will be given a copy of our current Notice.

Authorization Rule

We will not use or disclose your PHI for any purpose or to any person other than as stated in the rules above without your signature on our specifically worded, written Authorization / Acknowledgement

Form (not a Consent or an Acknowledgement). If we need your Authorization, we must obtain it via a specific Authorization Form, which may be separate from any Authorization / Acknowledge- ment we may have obtained from you. We will not condition your treatment here on whether you sign the Authorization (or not).

Marketing and Fund Raising Rules

Limitations on the disclosure of PHI regarding Remuneration

The disclosure or sale of your PHI without authorization is prohibited. Under the new HIPAA Omnibus Rule, this would exclude disclosures for public health purposes, for treatment / payment for healthcare, for the sale, transfer, merger, or consolidation of all or part of this facility and for related due diligence, to any of our Business Associates, in connection with the business associate's performance of activities for this facility, to a patient or beneficiary upon request, and as required by law. In addition, the disclosure of your PHI for research purposes or for any other purpose permitted by HIPAA will not be considered a prohibited disclosure if the only reimbursement received is "a reasonable, cost-based fee" to cover the cost to prepare and transmit your PHI which would be expressly permitted by law. Notably, under the Omnibus Rule, an authorization to disclose PHI must state that the disclosure will result in remuneration to the Covered Entity. Notwithstanding the changes in the Omnibus Rule, the disclosure of limited data sets (a form of PHI with a number of identifiers removed in accordance with specific HIPAA requirements) for remuneration pursuant to existing agreements is permissible until September 22, 2014, solong as the agreement is not modified within one year before that date.

Limitation on the Use of PHI for Paid Marketing

We will, in accordance with Federal and State Laws, obtain your written authorization to use or disclose your PHI for marketing purposes, (i.e.: to use your photo in ads) but not for activities that constitute treatment or healthcare operations. To clarify, Marketing is defined by HIPAA's Omnibus Rule, as "a communication about a product or service that encourages recipients… to purchase or use the product or service." Under the Omnibus Rule, we will obtain a written authorization from you prior to recommending you to an alternative therapist, or non-associated Healthcare Covered Entity.

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Notice of Privacy Practices (NOPP) for Protected Health Information

Under Omnibus Rule we will obtain your written authorization prior to using your PHI or making any treatment or healthcare recommendations, should financial remuneration for making the communication be involved from a third party whose product or service we might promote (i.e.: businesses offering this facility incentives to promote their products or services to you). This will also apply to our Business Associate who may receive such remuneration for making a treatment or healthcare recommendations to you. All such recommendations will be limited without your expressed written permission.

We must clarify to you that financial remuneration does not include "as in-kind payments" and payments for a purpose to implement a disease management program. Any promotional gifts of nominal value are not subject to the authorization requirement, and we will abide by the set terms of the law to accept or reject these.

The only exclusion to this would include: "refill reminders", so long as the remuneration for making such a communication is "reasonably related to our cost" for making such a communication. In accordance with law, this facility and our Business Associates will only ever seek reimbursement from you for permissible costs that include: labor, supplies, and postage. Please note that "generic equivalents" , "adherence to take medication as directed" and "self-administered drug or delivery system communications" are all considered to be "refill reminders."

Face-to-face marketing communications, such as sharing with you, a written product brochure or pamphlet, is permissible under current HIPAA Law.

Flexibility on the Use of PHI for Fundraising

Under the HIPAA Omnibus Rule use of PHI is more flexible and does not require your authorization should we choose to include you in any fund raising efforts attempted at this facility. However, we will offer the opportunity for you to "opt out" of receiving future fundraising communications. Simply let us know that you want to "opt out" of such situations. There will be a statement on your HIPAA Patient Acknowledgement Form where you can choose to "opt out". Our commitment to care and treat you will in no way effect your decision to participate or not participate in our fund raising efforts.

Improvements to Requirements for Authorizations Related to Research

Under HIPAA Omnibus Rule, we may seek authorizations from you for the use of your PHI for future research. However, we would have to make clear what those uses are in detail.

Also, if we request of you a compound authorization with regards to research, this facility would clarify that when a compound authorization is used, and research-related treatment is conditioned upon your authorization, the compound authorization will differentiate between the conditioned and unconditioned components.

Your Rights Regarding Your Protected Health Information

If you got this Notice via email or website, you have the right to get, at any time, a paper copy by asking our Privacy Officer. Also, you have the following additional rights regarding PHI we maintain about you:

To Inspect and Copy

You have the right to see and get a copy of your PHI including, but not limited to, medical and billing records by submitting a written request to our Privacy Officer. Original records will not leave the premises, will be available for inspection only during our regular business hours, and only if our Privacy Officer is present at all times. You may ask us to give you the copies in a format other than photocopies (and we will do so unless we determine that it is impractical) or ask us to prepare a summary in lieu of the copies. We may charge you a fee not to exceed state law to recover our costs (including postage, supplies, and staff time as applicable, but excluding staff time for search and retrieval) to duplicate or summarize your PHI. We will not condition release of the copies on summary of payment of your outstanding balance for professional services if you have one). We will comply with Federal Law to provide your PHI in an electronic format within the 30 days, to Federal specification, when you provide us with proper written request. Paper copy will also be made available. We will respond to requests in a timely manner, without delay for legal review, or, in less than thirty days if submitted in writing, and in ten business days or less if malpractice litigation or pre-suit production is involved. We may deny your request in certain limited circumstances (i.e. we do not have the PHI, it came from a confidential source, etc.). If we deny your request, you may ask for a review of that decision. If required by law, we will select a licensed healthcare professional (other than the person who denied your request initially) to review the denial and we will follow his or her decision. If we select a licensed healthcare professional who is not affiliated with us, we will ensure a Business Associate

Agreement is executed that prevents re-disclosure of your PHI without your consent by that outside professional.

To Request Amendment / Correction

If another doctor involved in your care tells us in writing to change your PHI, we will do so as expeditiously as possible upon receipt of the changes and will send you written confirmation that we have made the changes. If you think PHI we have about you is incorrect, or that something important is missing from your records, you may ask us to amend or correct it (so long as we have it) by submitting a "Request for Amendment / Correction" form to our Privacy Officer. We will act on your request within 30 days from receipt but we may extend our response time (within the 30-day period) no more than once and by no more than 30 days, or as per Federal Law allowances, in which case we will notify you in writing why and when we will be able to respond. If we grant your request, we will let you know within five business days, make the changes by noting (not deleting) what is incorrect or incomplete and adding to it the changed language, and send the changes within 5 business days to persons you ask us to and persons we know may rely on incorrect or incomplete PHI to your detriment (or already have). We may deny your request under certain circumstances (i.e. it is not in writing, it does not give a reason why you want the change, we did not create the PHI you want changed (and the entity that did can be contacted), it was compiled for use in litigation, or we determine it is accurate and complete). If we deny your request, we will (in writing within 5 business days) tell you why and how to file a complaint with us if you disagree, that you may submit a written disagreement with our denial (and we may submit a written rebuttal and give you a copy of it), that you may ask us to disclose your initial request and our denial when we make future disclosure of PHI pertaining to your request, and that you may complain to us and the U.S. Department of Health and Human Services.

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Notice of Privacy Practices (NOPP) for Protected Health Information

To an Accounting of Disclosures

You may ask us for a list of those who got your PHI from us by submitting a "Request for Accounting of Disclosures" form to us. The list will not cover some disclosures (i.e. PHI given to you, given to your legal representative, given to others for treatment, payment or health-care-operations purposes). Your request must state in what form you want the list (i.e. paper or electronically) and the time period you want us to cover, which may be up to but not more than the last six years (excluding dates before April 14, 2003). If you ask us for this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee to respond, in which case we will tell you the cost before we incur it and let you choose if you want to withdraw or modify your request to avoid the cost.

To Request Restrictions

You may ask us to limit how your PHI is used and disclosed (i.e. in addition to our rules as set forth in this Notice) by submitting a written "Request for Restrictions on Use, Disclosure" form to us (i.e. you may not want us to disclose your surgery to family members or friends involved in paying for our services or providing your home care). If we agree to these additional limitations, we will follow them except in an emergency where we will not have time to check for limitations. Also, in some circumstances we may be unable to grant your request (i.e. we are required by law to use or disclose your PHI in a manner that you want restricted, you signed an Authorization Form, which you may revoke, that allows us to use or disclose your PHI in the manner you want restricted; in an emergency).

To Request Alternative Communications

You may ask us to communicate with you in a different way or at a different place by submitting a written "Request for Alternative Communication" Form to us. We will not ask you why and we will accommodate all reasonable requests (which may include: to send appointment reminders in closed envelopes rather than by postcards, to send your PHI to a post office box instead of your home address, to communicate with you at a telephone number other than your home number). You must tell us the alternative means or location you want us to use and explain to our satisfaction how payment to us will be made if we communicate with you as you request.

To Complain or Get More Information

We will follow our rules as set forth in this Notice. If you want more information or if you believe your privacy rights have been violated (i.e. you disagree with a decision of ours about inspection / copying, amendment / correction, accounting of disclosures, restrictions or alternative communications), we want to make it right. We never will penalize you for filing a complaint. To do so, please file a formal, written complaint within 180 days with:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Ave., S.W.
Washington, DC 20201

877.696.6775

Or, submit a written Complaint form to us at the following address:

Cucamonga Valley Medical Group

16465 Sierra Lakes Parkway, Suite 300
Fontana, CA 92336

909.429.2864 | 909.429.2868

You may get your **"HIPAA Complaint"** form by calling our privacy officer.

These privacy practices are in accordance with the original HIPAA enforcement effective April 14, 2003, and undated to Omnibus Rule effective March 26, 2013 and will remain in effect until we replace them as specified by Federal and/or State Law.

Optional Rules For NOPP

Faxing and Emailing Rule

When you request us to fax or email your PHI as an alternative communication, we may agree to do so, but only after having our Privacy Officer or treating doctor review that request. For this communication, our Privacy Officer will confirm that the fax number or email address is correct before sending the message and ensure that the intended recipient has sole access to the fax machine or computer before sending the message; confirm receipt, locate our fax machine or computer in a secure location so unauthorized access and viewing is prevented; use a fax cover sheet so the PHI is not the first page to print out (because unauthorized persons may view the top page); and attach an appropriate notice to the message. Our emails are all encrypted per Federal Standard for your protection.

Practice Transition Rule

If we sell our practice, our patient records (including but not limited to your PHI) may be disclosed and physical

Notice of Privacy Practices (NOPP) for Protected Health Information

custody may be transferred to the purchasing healthcare provider, but only in accordance with the law. The healthcare provider who is the new records owner will be solely responsible for ensuring privacy of your PHI after the transfer and you agree that we will have no responsibility for (or duty associated with) transferred records. If all the owners of our practice die, our patient records (including but not limited to your PHI) must be transferred to another healthcare provider within 90 days to comply with State & Federal Laws. Before we transfer records in either of these two situations, our Privacy Officer will obtain a Business Associate Agreement from the purchaser and review your PHI for super-confidential information (i.e. communicable disease records), which will not be transferred without your express written authorization (indicated by your initials on our Consent form).

Inactive Patient Records

We will retain your records for seven years from your last treatment or examination, at which point you will become an inactive patient in our practice and we may destroy your records at that time (but records of inactive minor patients will not be destroyed before the child's eighteenth birthday). We will do so only in accordance with the law (i.e. in a confidential manner, with a Business Associate Agreement prohibiting re-disclosure if necessary).

Collections

If we use or disclose your PHI for collections purposes, we will do so only in accordance with the law.

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Authorization to Release or Receive Medical Records

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Privacy Act:

PATIENT'S FIRST AND LAST NAME | SOCIAL SECURITY NUMBER

STREET ADDRESS

CITY | STATE | ZIP

PHONE | CELL | BIRTHDATE

This form can be emailed to: Records@CVMGdocs.com

I hereby authorize (those named below):

NAME OF PHYSICIAN / PROVIDER

STREET ADDRESS

CITY | STATE | ZIP

PHONE | FAX

to furnish to (those named below):

NAME OF PHYSICIAN / PROVIDER

STREET ADDRESS

CITY | STATE | ZIP

PHONE | FAX

Purpose for Disclosure: ☐ Continuing Care ☐ Insurance ☐ Legal Purposes ☐ Personal Use

☐ Other / Specify: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the following information from service dates _____ to _____

I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. Unless otherwise revoked, this authorization will expire one year from the date of signature. I understand that signing this form is voluntary, and that I may revoke this authorization at any time in writing, which must be mailed to ***16465 Sierra Lakes Parkway, Suite 300, Fontana, CA 92336***. I understand that I have the right to inspect and/or obtain a copy of the material to be disclosed. Cucamonga Valley Medical Group will not re-disclose this information, except with a written authorization or as specifically required or permitted by law. Cucamonga Valley Medical Group will not condition the provision of care or the receipt of benefits on signing this authorization. A copy of this authorization shall be as effective as the original and I have the right to receive a copy of this authorization. I release, hold harmless and agree to indemnify this Healthcare Facility, it's employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent.

I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP. *Initial where appropriate:*

_____ INITIALS Alcohol and substance abuse diagnosis and treatment records

_____ INITIALS HIV records (including HIV test results) and sexually transmissible diseases

_____ INITIALS Mental Health Records

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN | DATE

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE (IF APPLICABLE) | DATE

PRINT NAME OF PATIENT'S LEGAL REPRESENTATIVE (IF APPLICABLE) | RELATIONSHIP TO PATIENT

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Patient Health Questionnaire

PATIENT'S FIRST AND LAST NAME | DATE OF BIRTH | DATE

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Check box to indicate your answer)

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, *or* sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
ANSWER VALUE:	0	1	2	3

Provider Portion - DO NOT FILL

TOTAL SCORE:

Interpretation:

- ☐ MINIMAL DEPRESSION
- ☐ MILD DEPRESSION
- ☐ MODERATE DEPRESSION
- ☐ MODERATELY SEVERE DEPRESSION
- ☐ SEVERE DEPRESSION

Interpretation of Total Score for Depression Severity

1–4	Minimal depression
5–9	Mild depression
10–14	Moderate depression
15–19	Moderately severe depression
20–27	Severe depression

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Tuberculosis Screening Questionnaire

PATIENT'S FIRST AND LAST NAME

DATE

Thank you for taking the time to answer the following questions in preparation for your Tuberculosis Exam.		
1. Have you or anyone you see regularly been diagnosed or suspected of being sick with active tuberculosis?	☐ Yes	☐ No
2. Do you have family members of frequent visitors who were born in high TB prevalence countries (Asia, Africa, Latin America, Eastern Europe)?	☐ Yes	☐ No
3. Were you born in, or do you travel to high TB prevalence countries (Asia, Africa, Latin America, Eastern Europe)?	☐ Yes	☐ No
4. Do you live in out-of-home placements (such as foster care or residential facilities)?	☐ Yes	☐ No
5. Do you have HIV infection or other immunosuppressive conditions?	☐ Yes	☐ No
6. Do you live with someone with HIV seropositivity?	☐ Yes	☐ No
7. Do you live or frequently visit with persons who have been incarcerated in the last 5 years?	☐ Yes	☐ No
8. Do you live among or are you frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes?	☐ Yes	☐ No
9. Do you consume alcoholic beverages?	☐ Yes	☐ No
10. Do you work in health care?	☐ Yes	☐ No
11. Have you ever had positive TB test?	☐ Yes	☐ No
12. Have you received any vaccinations against TB?	☐ Yes	☐ No

13. When was your last TB test?

Please return your completed form to the Medical Assistant when you are called to the examination room. Thank You.