Notice of Privacy Practices

Jason Shupe, D.O., An Osteopathic Corporation
554 E. Foothill Blvd; Suite 120
San Dimas, CA 91773

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

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.
- We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
- We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.
The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
The right to inspect and copy your PHI.
The right to amend your PHI.
The right to receive an accounting of disclosures of your PHI.
The right to obtain a paper copy of this notice from us upon request.
The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of 7/10/2019 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

> Feel free to contact the Practice Compliance Officer Jason Shupe at 909.248-3437 for more information, in person or in writing.

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AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

1. I hereby consent to, and authorize all treatment that may be considered necessary or advisable by the physician. I understand that no guarantee or assurance has been made of the results that may be obtained.

2. I understand that this office may have medical students and residents rotating with the doctor. When I am treated, I understand that there may be one or more students participating in my care. I have been advised that if there are some things that I am only comfortable discussing with the doctor alone, I will let the doctor know. I understand that I am free to request more time with the doctor if I need it. I understand that if this is not acceptable to me, that the doctor will be more than happy to refer me to another physician.

3. I understand that payment is required at the time of visit. I understand that that I am financially responsible for all charges. I understand outside lab, x-ray and other ancillary charges will be billed by the providing facility and are not connected with this office.

4. I also understand that I am to give 24 hours notice if I need to cancel my appointment. I understand there is a charge of $25.00 the second time an appointment is missed. If this agreement continues to be abused I will be expected to pay for the missed appointments from the third missed appointment. (Medical insurance does not pay for missed appointments, so you will be expected to pay for these yourself).

5. I have received a copy of Jason Shupe, D.O., An Osteopathic Corporation's Notice of Privacy Practices.

Date _____ Signature _____
(patient)

Authorized person_____ Relationship to patient _____

(All authorizations must be signed by the patient or by an authorized person in the case of a minor, or when the patient otherwise lacks capacity.)

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PATIENT INFORMATION Today's Date_____

Last Name _____ Middle Initial ____ First Name _____

Date of Birth _____ Gender _____

Address _____
Street Address City
State Zip Code

Phone 1 _____ Phone 2 _____

Email _____

How did you hear about us? _____

EMERGENCY CONTACT NAME AND INFORMATION

Name of person to contact in case of an emergency _____

Contact Phone 1 _____ Phone 2 _____

Contact's Relationship to you _____

What is the reason for your visit today? _____

_____

_____

Primary Care Physician _____

Address _____
Street Address City
State Zip Code

ALLERGIES:

Medication / Food / Insect / Iodine / Latex / Other	Reaction

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MEDICATIONS:

Name	Dose	Frequency

CONDITIONS: Please circle YES or NO for any problem that you have had:

Anemia	YES	NO	Kidney disease	YES	NO
Anorexia	YES	NO	Liver disease	YES	NO
Anxiety	YES	NO	Measles	YES	NO
Arthritis	YES	NO	Migraines	YES	NO
Asthma / Bronchitis / COPD	YES	NO	Miscarriage	YES	NO
Bipolar	YES	NO	Mononucleosis	YES	NO
Bleeding disorder	YES	NO	Multiple Sclerosis	YES	NO
Bulimia	YES	NO	Mumps	YES	NO
Cancer	YES	NO	Pacemaker	YES	NO
Cataracts	YES	NO	Pneumonia	YES	NO
Concussion	YES	NO	Polio	YES	NO
Depression	YES	NO	Prostate problem	YES	NO
Diabetes	YES	NO	Postpartum blues	YES	NO
Drug / Alcohol dependency	YES	NO	Psychiatric care	YES	NO
Epilepsy / Seizures	YES	NO	Rheumatic fever	YES	NO
Glaucoma	YES	NO	Rheumatoid arthritis	YES	NO
Gout	YES	NO	Scarlet fever	YES	NO
Hay fever / Sinus problems	YES	NO	Stroke	YES	NO
Heart problems	YES	NO	Stomach ulcers	YES	NO
Hepatitis	YES	NO	Suicide attempt	YES	NO
Hernia	YES	NO	Suicidal thoughs	YES	NO

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Conditions (continued) Please circle YES or NO for any problem that you have had:

Hiatal hernia	YES	NO	Thyroid problems	YES	NO
High blood pressure	YES	NO	Tonsillitis	YES	NO
High cholesterol	YES	NO	Tuberculosis	YES	NO
HIV positive	YES	NO	Typhoid Fever	YES	NO
Joint replacement	YES	NO	Other (please list below)		

_____
_____
_____
_____

Serious Injuries, Fractures, Illnesses. Hospitalizations or Surgeries:

Event	Date

FAMILY HISTORY:

Problem	Circle YES or NO		Relationship
Allergies	YES	NO	
Asthma / Bronchitis / COPD	YES	NO	
Anemia	YES	NO	
Arthritis	YES	NO	
Alcohol dependence	YES	NO	
Bleeding disorder	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Epilepsy / Seizures	YES	NO	
Glaucoma	YES	NO	
Genetic Disease	YES	NO	
Heart problems	YES	NO	
High blood pressure	YES	NO	
High cholesterol	YES	NO	
Kidney Disease	YES	NO	

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Family History (continued)

Problem	Circle YES or NO		Relationship
Mental Illness	YES	NO	
Stroke	YES	NO	
Tuberculosis	YES	NO	
Other (list below)	YES	NO	

_____

_____

_____

SYMPTOMS:

	ongoing	past	duration		ongoing	past	duration		ongoing	past	duration
Chills				Allergies/Hay fever				Poor circulation			
Dizziness				Bleeding gums				Shortness of breath			
Easy bruising				Decreased hearing				/w exertion			
Fainting				Earache				/w lying flat			
Fatigue				Ear discharge				Swollen ankles			
Fever				Ear fullness				Varicose veins			
Forgetfulness				Ear ringing/buzzing				Dry cough			
Loss of energy				Hoarseness				Productive cough			
Loss of sleep				Jaw clicking				Bloody sputum			
Motion sickness				Jaw locking				Wheezing			
Nervousness				Nosebleeds				Abdominal pain			
Sweating				Post-nasal drip				Black stools			
Unsteadiness				Sinus problems				Bloating			
Weight loss				Sore throat				Constipation			
Weight gain				Trouble swallowing				Diarrhea			
Blurred vision				Chest pain				Heartburn			
Lazy/crossed eye(s)				Chest pressure				Hemmorhoids			
Eye pain				Heart murmur				Mucous in stools			
Farsightedness				High blood pressure				Nausea			
Loss of vision				Irregular heart beat				Vomiting			
Nearsightedness				Let pain w/ walking				Cold extremities			
Visual flashes				Low blood pressure				Numb extremities			
Laser eye surgery				Palpitations				Convulsions			
Corrective lenses				Phlebitis				Headaches			

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Symptoms (continued) :

	ongoing	past	duration		ongoing	past	duration		ongoing	past	duration
Memory loss				Scars				Joint swelling			
Moodiness				Sores that won't heal				Neck pain			
Muscle weakness				Yellow skin or eyes				Shoulder pain			
Tremors				Bladder control				Hand pain			
Phobias				Blood in urine				Hip pain			
Vertigo/spinning				Painful intercourse				Foot pain			
Change in moles				Painful urination				Jaw pain			
Eczema				Pelvic pain				Arm pain			
Hives				Sexual dysfunction				Back pain			
Itching				Urinary hesitancy				Leg pain			
Psoriasis				Weak urinary stream				Other pain			
Rashes				Joint stiffness							

Female History:
Total number of pregnancies: ____ Term: ___ Premature: ___ Miscarriages: ___ Abortions: ___ Living: ____
Age of onset of Menses: ____ Date of last period: ____ Method of birth control: _____
Periods are: Regular: __ Irregular: __ Painful: __ Heavy: __ Scant: __ Days of flow: ___ Days in between: ___

Self Care activities that I engage in on a weekly basis:

Activity	Times per week	Duration
Exercise		
Meditative Practices		

Typical Breakfasts: _____
_____

Typical Lunch: _____
_____

Typical Dinner: _____
_____

Typical Snacks: _____
_____

Typical Deserts: _____
_____

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Substances:	Quantity	Frequency
Alcohol		
Caffeine		
Chocolate		
Drugs		
Sugar		
THC/CBD		
Tobacco		
Water		
Other		