FOCUSHEALTH

Adult Confidential Health Questionnaire

Patient Name	Date of Birth	Date/Time:
Preferred name (if different from above)	Preferred Language	Will you need an interpreter? ☐ Yes ☐ No

Your answers on this form will help your clinician understand your medical concerns and conditions. If any question makes you uncomfortable or is not applicable, feel free to leave it blank. Estimate dates, if you cannot remember specific details and exact dates.

We recommend our patient portal, SharpApp, as a preferred means of communication with your provider.

What is the best way for our office to contact you? ☐ *Phone* ☐ *Patient Portal – SharpApp(MyChart)*

Do you give us permission to leave detailed messages regarding lab results, information, etc.? ☐YES ☐NO

PERSONAL INFORMATION:

Primary Phone number	Alternate Phone Number	Email Address

Home Address:

Street Address	City/Town	State	Zip code

Mailing Address: ☐ Same as Home Address

Street Address	City/Town	State	Zip code

Present Health Concerns: _____

_____

_____

Do you have any Health Care Goals you'd like to discuss today? _____

_____

_____

In general, would you say your health is: ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

MEDICATION: ☐ No regular medication

Name Medication	***Dose***	***Times Per Day***

PHARMACY:

Pharmacy Name	Address	Phone

ALLERGIES: To medications or food: ☐ No known allergies

Allergy	***Reaction or Side Effect***

IMMUNIZATIONS: Please list your most recent immunizations. Please include your best estimate of the month and year of each immunization: ☐ Not vaccinated

Hepatitis A	Tetanus (Td)	Mumps	Pneumovax (Pneumonia)
Hepatitis B	Meningitis	Rubella	Varicella (Chickenpox)
HPV	Measles	MMR	Shingles
Other:	Other:	Other:	Other:

SELF / FAMILY MEDICAL HISTORY: Please indicate if you or any family members have had any of the following conditions: ☐ I do not know my family history

Medical Condition	***Self***	***Mom***	***Dad***	***Sist.***	***Bro.***	***Daug***	***Son***	***Othe***	***Medical Condition***	***Self***	***Mom***	***Dad***	***Sist.***	***Bro.***	***Daug***	***Son***	***Othe***
Alcoholism									Glaucoma								
Anemia									Hay fever (Allergies)								
Allergies (environmental)									Hearing problems								
Anesthesia problem									Heart Attack (CAD)								
Anxiety/Depression									Heart Valve Problems								
Arthritis									High Blood Pressure								
Asthma									High cholesterol								
Atrial Fibrillation									Kidney diseases								
Birth Defects									Lupus (SLE)								
Blood Transfusion									Developmental delay								
Cancer, Breast									Migraine								
Cancer, Colon									Obesity								
Cancer, Melanoma									Osteoarthritis								
Cancer, Ovary									Osteoporosis								
Cancer, Prostate									Polycystic Ovaries								
Cancer, Thyroid									Psychiatric Hospitalizations								
Cancer, other known site									Pulmonary Embolism								
Coagulation (bleeding/clotting problem)									Rheumatoid Arthritis								
Colon Polyps									Seizures								
Dementia									Stroke (CVA)								

Depression										Thyroid, Under Active									
Diabetes, Type 1 (child)										Thyroid, Hyperactive									
Diabetes, Type 2 (adult)										Tuberculosis/PPD+									
Epilepsy (Seizures)										Other:									
Genetic diseases										Other:									
GI diseases										Other:									

If parents are deceased, at what age did they pass away?

Father's Age	Cause	Mother's Age	Cause

SURGICAL AND PROCEDURAL HISTORY: Please list all prior operations and/or procedures with dates (excluding dental surgeries/procedures): ☐ I have had no prior surgery

Operation	Date

HOSPITALIZATIONS IN THE LAST YEAR: Please list all prior hospitalizations within the last year:

☐ I have had no hospitalizations this past year

Reason for Hospital Stay	Date

GENERAL HEALTH QUESTIONS:

Date of your last colonoscopy: _____Result of colonoscopy: _____

Advanced Directive:

Do you have an Advanced Directive? ☐ Yes ☐ No Would you like to create one? ☐ Yes ☐ No

Employment Status:

☐ Full Time ☐ Part Time ☐ Not Employed How Long?_____ Occupation: _____

Any Occupational Risks?_____ If not employed, are you registered disabled? ☐ Yes ☐ No

Civil Status:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partnership For how long:_____

Education Level Completed:

☐ Less than High School ☐ High School ☐ College ☐ Graduate School ☐ Other:_____

Exercise: How active are you?

☐ I get a cardiovascular work-out 3 or more times/ week ☐ I walk daily but do not work out
☐ I exercise or walk less than 3 times/ week ☐ I am not generally active ☐ Other:_____

Tobacco Use: Please check one:

☐ I have never smoked ☐ I have smoked, but rarely. When was the last time?_____
☐ I have quit smoking. Quit Date:_____ ☐ I currently smoke
History: _____pack(s) / day, # of years _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ Yes ☐ No ☐ N/A

Drug Use

Do you use any recreational drugs? ☐ Yes ☐ No Have you ever used needles? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Regularly
Average # drinks per day: _____, # per week: _____
Types of drinks: ☐ 5oz wine ☐ 12oz beer ☐ 1.5oz hard liquor
Is alcohol use a concern for you or others? ☐ Yes ☐ No

Sexual Activity

Sexually Active: ☐ Yes ☐ No ☐ Not Currently
If sexually active, do you practice safe sex? ☐ Yes ☐ No
Current sex partner(s) is/are: ☐ Male ☐ Female
Have you ever had any sexually transmitted diseases (STDs)? ☐ Yes ☐ No
Type:_____ Date: _____
Type:_____ Date: _____
Are you interested in being screened for STDs? ☐ Yes ☐ No
Other Concerns: _____

Sleep

Do you have trouble sleeping at night? ☐ Yes ☐ No
Do you snore or has anyone told you that you snore? ☐ Yes ☐ No
About how many hours a night do you sleep?_____

Safety

Do you use seatbelts consistently? ☐ N/A ☐ Yes ☐ No
Do you use a bike helmet regularly? ☐ N/A ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Are you currently in a relationship? ☐ Yes ☐ No
If yes, do you feel safe in this relationship? ☐ Yes ☐ No
Do you have a gun in your home? ☐ Yes ☐ No

Stress: How often is stress a problem for you in handling such things as:

Your health? ☐ Always ☐ Often ☐ Sometimes ☐ Never
Your finances? ☐ Always ☐ Often ☐ Sometimes ☐ Never
Your work? ☐ Always ☐ Often ☐ Sometimes ☐ Never
Your family or social relationships? ☐ Always ☐ Often ☐ Sometimes ☐ Never

Emotions: Please rate each question, using the following scale:

0= Not at all 1 = Several days 2 = More than half 3 = Nearly every day

Over the past two weeks, how often have you been bothered by any of the following problems?
1) Little interest or pleasure in doing things?_____ 2) Feeling down, depressed or hopeless? _____

Social/Emotional Support

Who do you live with? _____

How often do you get the social and emotional support you need?
☐ Always ☐ Often ☐ Sometimes ☐ Never

Recreational and Social Activities: In the past 3 months:

How often have you done activities that you enjoy? ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
List Activities: _____
How often do you spend time with family and friends? ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Transportation Needs: In the past 12 months, has lack of transportation kept you from any of the below activities? (Check all that apply)

☐ Yes, it has kept me from medical appointments or getting medications
☐ Yes, it has kept me from non-medical meetings appointments, work, or getting things that I need
☐ No

Food Insecurity:

Within the past 12 months, you worried whether your food would run out before you got money to buy more. ☐ Often ☐ Sometimes ☐ Never ☐ Don't Know/ Refused

Within the past 12 months the food you bought just didn't last and you didn't have money to get more.
☐ Often ☐ Sometimes ☐ Never ☐ Don't Know/ Refused

MEN'S HEALTH HISTORY : ☐ Not Applicable

When was your last Prostate Exam? _____ *Results:*_____
Have you had any Prostate problems? ☐ No ☐ Yes _____
Did you have any treatment? ☐ No ☐ Yes_____
Do you have concerns about erectile dysfunction? ☐ No ☐ Yes

WOMEN'S GYNECOLOGIC HISTORY: ☐ Not Applicable

When was your last mammogram? _____ *Results:*_____

Number of Pregnancies: _____ # deliveries: _____ # abortions: _____ # miscarriages:_____

Menstrual cycle:

1st day, most recent period:_____ Age at 1st period: _____

Frequency:_____ Length: _____

Do you have any concerns about your periods? ☐ No ☐ Yes: _____

_____

If you have stopped having periods, please specify age when you reached menopause:_____

Do you have any concerns about menopause? ☐ N/A ☐ No ☐ Yes:_____

_____

When was your last Pap Test?_____ *Results:*_____

Have you ever had an abnormal Pap test? ☐ No ☐ Yes: _____

Are you currently on birth control? ☐ No ☐ Yes:_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient or Representative Signature	Date	Time
Patient or Representative Printed Name	Relationship to Patient	

FOCUSHEALTH

Authorization for Release of Information to Family Member

Patient Name: _____Date of Birth: _____

Under the requirements of HIPAA (Patient Privacy Act) we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information released to family members, caregivers, or others you must sign this form. Signing this form will only give information to the
specified people listed below.

You may speak to following people about my health and disclose my health information, that I have circled:

1. _____ DOB:_____ Relation to Patient: _____
2. _____ DOB:_____ Relation to Patient: _____
3. _____ DOB:_____ Relation to Patient: _____
4. _____ DOB:_____ Relation to Patient: _____
5. _____ DOB:_____ Relation to Patient: _____

You may disclose my (please circle)

Visit Notes Rendered	**Labs/X-rays**	**HIV & Related Information**	**Mental Health**	**All Service & Treatment**

I have the right to revoke this authorization at any time by writing. This will be effective until that time.

Patient or Representative Signature	Date	Time
Patient or Representative Printed Name	Relationship to Patient	

Revoked: I choose to revoke the above release on effective the date below immediately:

Patient Signature: _____Date/Time: _____

Updated 06/04/2024

Faxed Form on: _____ Initials: _____

Focus Health
8765 Aero Dr., Suite 130, San Diego, CA 92123
Phone: (858) 541-0181 FAX: (858) 637-9035

FOCUSHEALTH

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient Name: AKA: _____ Date of Birth: _____

Address: _____ City/State/Zip:

Phone: _____ Email: _____

Purpose of the Request or Disclosure:

☐ Patient Care ☐ Self ☐ Legal ☐ Provider Form ☐ Other: _____

☐ SEND TO ☐ OBTAIN FROM ☐ VERBAL COMMUNICATION

Name of Authorized Person or Facility: _____

Address of Person or Facility: _____

Phone #: _____ Fax #: _____

Email: _____

I Authorize Release of the Following Records (check all that apply): ☐ ☐

☐ Medical Information ☐ HIV & Related Information STDs Substance Abuse Mental Health*Includes Drug/Alcohol/HIV related*

For Dates of Service:

From: _____ To: _____

Description of the Information to be Disclosed *(check all that apply)*:

☐ Immunization ☐ Progress Note ☐ Lab ☐ Results Reports ☐ Consults

☐ Procedures ☐ Imagining ☐ EKG ☐ Other: _____

Records needed by *(if possible, we will complete by requested date)*: _____

Indicate how to release information:

☐ Paper Copy ☐ Fax ☐ Email ☐ 3rd Party choice

**More than 10 pgs, will go through out copy service and can take up to 7-14 business days to be completed

I hereby release Focus Health from any and all liability which may arise as a result of my authorized release of records. I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorizationshall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already releases copies.

Signature of Patient *(or legal representative)*: _____ Date: _____ Time: _____

**3rd Party Notes - If over 30 pages, please email, fax or mail ** We do not accept CDs **

Updated: 06/03/2024

FOCUSHEALTH

Practice Policies

Thank you for choosing FocusHealth as your primary care provider. We are committed to providing you with quality and affordable health care. Please find our office policies below for your review and acknowledgement.

- **Documents:** Copies of your current insurance cards and identification are required annually and with any changes. These can be provided at the time of visit or uploaded through the *SharpApp* patient portal.
- **Phones:** Telephones are answered Monday through Friday 8:00am – 5:00pm. Holidays and after hours will be handled by the answering service.
- **Emergencies:** Our practice has a provider on-call for patient emergencies that may occur after hours. Please note that prescription refills and referrals will be addressed during normal business hours only.
- **Cancellations:** For appointments that need to be cancelled or rescheduled, please notify us at least one (1) business day prior to the scheduled appointment to avoid any possible No-Show fees.
- **Late Arrivals:** Patients are asked to arrive fifteen (15) minutes prior to a scheduled appointment for check-in. Patients that arrive more than five (5) minutes after the scheduled appointment time, may be asked to reschedule.
- **Patient Portal:** Our practice utilizes *SharpApp (MyChart)*, a secure on-line patient portal. Using either Smartphone app or PC, you can access *SharpApp* for scheduling appointments, communicating with your care team, reviewing test results, and other features. Please allow up to two (2) business days for a response to any messages sent to your provider.
- **Prescriptions:** All prescription refills requests should be submitted through your pharmacy. Refill requests will be handled within two (2) business days once request is received. Please note that prescription refills will be addressed during normal business hours only.
- **Referrals:** Routine referrals to other physicians or diagnostic facilities can take up to fourteen (14) business day to process. Urgent referrals may take up to three (3) business days. Any new referral requests will require a visit with a provider.
- **Test Results:** Lab and imaging results ordered by your provider should be available within five (5) business days once results received and reviewed by the provider. Results will be communicated on the SharpApp or via telephone call, as appropriate.
- **Medical Records:** Record requests will be processed within ten (10) business days. Release of Information Authorization is required to release records to a third party, without charge. Individual records request fee is $15 for the first ten (10) pages and $0.50 for each additional page. Please note that most records may be located and printed from the SharpApp, which is available without cost.

- **Form Completion:** Forms will be completed when accompanied by an office visit, at no additional charge. Requests for form completion outside of an office visit will incur a charge based on form type, which cannot be billed to insurance, and are due at the time of the request. Please allow five (5) business days for completion.
- **Preventive Care Services:** Many preventive services are covered as part of insurance benefits. However, please be aware that if an additional problem is addressed during a preventive visit, a copay, deductible or office visit fee may be charged.
- **Co-Payments:** Co-payments are required to be collected at the time of service.
- **Deductible Payments:** You may be required by your insurance to meet a deductible before services are covered, payment must be made at the time of service. For all deductibles greater than $100 will require a minimum of $100 payment at the time of service. Please note you will be billed for any remaining balance.
- **Claims Submission:** Claims will be submitted to the insurance provider following your visit based on the that was information provided for that visit. All non-covered services are the responsibility of the patient or account guarantor. Any questions or concerns with claims submitted to the insurance, please contact our billing department. Any questions or concerns with the amount covered or denied by the insurance should be directed to the insurance provider. Any unpaid or past due amounts are subject to collections. *If at any time you should experience financial hardship, please contact our billing department.*
- **Cash Pay Patients:** Cash Pay can be accepted in the absence insurance coverage, payment will be collected at the time of service. Additional costs may be incurred for laboratory tests, imaging studies, medications, special procedure(s) or additional services ordered by the provider as deemed necessary during the visit.
- **Laboratory Bills:** Any laboratory procedures that are ordered will be billed to you directly by the performing laboratory. Any questions regarding laboratory bills should be directed to the performing laboratory.

I have read and received a copy and understand the above statements. I agree to comply with the financial policies of the office, and I am financially responsible for my account.

Patient or Representative Signature	Date	Time
Patient or Representative Printed Name	Relationship to Patient	

FOCUSHEALTH

FOCUSHEALTH CONDITIONS OF REGISTRATION AND AGREEMENT

If the patient is a minor, the parent, legal guardian, or authorized person (in writing) must sign. If the patient is incompetent, a legal guardian or conservator must sign.

MEDICAL CONSENT

The undersigned consents to any and all services that do not require informed written consent.

RELEASE OF INFORMATION

The undersigned acknowledges receiving FocusHealth's Notice of Privacy Practices.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she/they sign(s) as an agent or as a patient, that in consideration of the services to be rendered to the patient, he/she/they hereby individually obligates him/herself/themself to pay all monies due in accordance with the regular rates and terms of **FocusHealth**. In addition, the undersigned understands that any deposit made for services incurred is merely a deposit and that he/she/they will be financially responsible for all charges incurred.

Co-payments, coinsurance, payments for non-covered services (including services deemed experimental or not medically necessary by your health plan), and/or deductibles are due at the time of the visit. Monies not collected at the time of the visit will be the patient's responsibility. Furthermore, the undersigned authorizes **FocusHealth** to check and/or verify all references and financial information about him/her that is pertinent to his/her account, including but not limited to credit reports.

All patient accounts are due and payable upon receipt of a billing statement. If it is necessary to employ a professional collection agency and/or attorney to enforce this Agreement or to collect a judgment based on this Agreement, the patient or the person responsible for payment of fees related to the account that is the subject of this Agreement promises to pay all applicable interest, court costs, and attorney fees.

ELIGIBILITY GUARANTEE

The undersigned agrees that he/she/they must be eligible for their health insurance plan at the time of the visit. In addition, should the eligibility status of the patient's insurance terminate retroactively, the patient will be financially responsible for any services provided.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, where he/she/they signs as an agent or a patient and hereby assigns all benefits, checks or money to which he/she/they may be entitled directly or

indirectly as a result of coverage from an insurance or other health care benefits plan to **FocusHealth.** The undersigned understands and agrees that collection, billing and negotiation of payment from his/her/their insurance carrier is their sole responsibility. Any assistance **FocusHealth** may offer in processing the patient's claim will not relieve the patient of this responsibility. The undersigned also understands and agrees (this assignment of benefits notwithstanding) that he/she/they is/are responsible for full and timely payment to **FocusHealth** even if an insurance claim is pending.

ASSIGNMENT OF MEDICARE AND MEDI-CAL BENEFITS

The undersigned requests that payment of authorized Medicare or Medi-Cal benefits be made on the patient's behalf to **FocusHealth** for any services furnished to the patient by that physician or supplier. The undersigned authorizes any holder of medical information about him/her/them to be released to the Centers for Medicare and Medicaid Services (and its agents) and/or to the California Department of Health Services (and its agents), as applicable, any such information needed to determine the benefits payable for related services. The undersigned understands that their signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on Item 9 of the CMS-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, the undersigned signature authorizes release of the information to the insurer or agency. In Medicare-assigned cases, the physician 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 non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

CONSENT TO TELEHEALTH AND VIRTUAL CARE

The undersigned consents to receive services via telehealth and virtual care from the physicians and other healthcare providers of **FocusHealth**. This includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary in the Providers' professional judgment. The undersigned agrees communications technology used in telehealth and virtual care may involve the use of interactive, real-time audio/visual technology (for example, video conferencing), email or text messages, or direct electronic transfer of information between computers or other electronic devices. These methods involve a chance that the exchanged information may be incomplete, lost, or otherwise disrupted by technical failures. The laws that protect the privacy and confidentiality of medical information also apply when services are provided via telehealth and virtual care. The undersigned assumes all risk if using a publicly accessible computer or publicly available platform, and there is a chance that the information may be accessed by unauthorized persons, which may result in a breach of patient confidentiality and privacy. The undersigned understands that there is a possibility that non-medical personnel may be involved in support of the visit. The Providers, at their discretion, may discontinue a telehealth or virtual encounter at any time and schedule an in-person visit. The patient understands that their Provider will be billing for the encounter and insurance payment for the encounter is subject to their health plan coverage at the time of the encounter.

NON-RESPONSIBILITY
The undersigned agrees that **FocusHealth** and its physicians shall not be responsible for the errors or omissions of the employees or contractors of other health care providers who provide services to the undersigned during the course of their treatment by **FocusHealth**.

MEDICAL RECORDS
To help coordinate your care, **FocusHealth** uses a unified electronic medical record system that is shared by all Sharp Healthcare Affiliated physicians and all physicians on the electronic medical record system, nurse practitioners, physician assistants, including those in Sharp Healthcare Affiliated Occupational Medicine department.

The undersigned certifies they have read the forgoing, received a copy thereof, and is the patient or the patient's legal representative or is fully authorized by the patient as the patient's general agent to execute this Agreement and accept its terms.

SUNSHINE ACT AND OPEN PAYMENTS DISCLOSURE
For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

This data is published annually in a database known as Open Payments. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

HIPAA Acknowledgement
I (the patient or the patient's legal representative) have been given access to **FocusHealth** Notice of Privacy Practices and Patient Rights and Responsibilities. These documents describe how medical information about me may be used and disclosed. This document also describes how I can access my medical information should I need it. I know that I can have a copy of this notice at any time upon request.

I understand my rights regarding the handling of my Protected Health Information as a patient of **FocusHealth**.

Our practice uses Sharp HealthCare's EHR platform. At Sharp HealthCare, we're proud to participate in health information exchanges. This allows participating hospitals and health care providers to safely and securely share patient health information — resulting in a more complete, current medical record that helps patients receive the best care possible.

The electronic exchange reduces the likelihood of undergoing redundant tests and procedures and lessening your burden of keeping track of and transferring your medical documents to each of your doctors. Sharp will only send patient health information

through health information exchanges if and when you seek treatment from a doctor outside of Sharp who participates in the exchange.

For more information, visit Health information exchange | Sharp HealthCare

If you do not want your information shared, please check the box below:

[ ] No

If signed by other than patient, indicate relationship to patient:

Signature:

Name (Print):

Relationship (if other than patient):

_____ _____

Date:

_____

FOCUSHEALTH

NOTICE OF PRIVACY PRACTICES

Effective Date: January, 2025
(Required by federal regulation 45 CFR 164.520)252

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.

Our Pledge Regarding Your Health Information

We understand that information about you and your health is confidential. We are committed to protecting the privacy of this information. Each time you visit a FocusHealth facility we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care created by any of the FocusHealth affiliated entities, whether made by any health care personnel or your physician.

This notice describes your health care information privacy rights and the obligations FocusHealth has regarding how we may use and disclose your health information.

Our Responsibilities

Federal and California law makes us responsible for safeguarding your protected health information. We must provide you with this notice of our privacy practices and follow the terms of the notice currently in effect. We will notify you if a breach of your protected health information occurs and we will not disclose your information (other than as described below) without your written permission.

Changes to this notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your current health information and any information we receive in the future. We will post a copy of the current notice throughout our organization and on our Web site at **www.sharp.com.** A copy of the notice currently in effect will be available at the registration area of each FocusHealth HealthCare facility.

How We May Use and Disclose Your Protected Health Information

California and federal law permits disclosures of your health information without any verbal or written permission from you. The following categories describe different ways that we use your health information within FocusHealth and disclose your health information to persons and entities outside of FocusHealth. We have not listed every use or disclosure within the categories below. For more information on how we can use your protected health information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Your Contact Information: We may use and disclose your contact information. Some examples of how this information may be used include appointment reminders, to update you on your care or care-management options, or to work with you on payment arrangements. By providing us with your contact information, you give your consent that we may use it. We may contact you by the following means (even if we initiate contact using an automated telephone dialing system and/or an artificial or prerecorded voice):

- a paging service,
- cellular telephone service,

- specialized mobile radio service,
- other radio common carrier service, or
- any other service that charges you for receiving the contact.

Treatment: We may use your health information to provide or coordinate your medical treatment and services. We may disclose health information about you to doctors, nurses, technicians, medical students, interns or other allied health personnel who are involved in providing for your well-being during your visit with us. We also may communicate information to another non-Focus health care provider for the purposes of coordinating your continuing care.

Payment: We may use and disclose your information for billing and to arrange for payment from you, an insurance company, a third party or a collection agency. This also may include the disclosure of health information to obtain prior authorization for treatment and procedures from your insurance plan.

Health Care Operations: We may use and disclose relevant health information about you for health care operations, a variety of activities necessary to operate our health care facility and to make sure all of our patients receive quality care. Examples include:

- quality assurance activities
- post-discharge telephone calls to follow-up on your health status
- granting medical staff credentials
- administrative activities, including FocusHealth financial and business planning and development
- customer service activities including investigation of complaints, and
- certain marketing activities such as health education options for treatment and services

Fund Raising: We may use demographic information and your dates of service for our own fundraising purposes. If you would prefer not to receive fundraising material, you may choose to opt out of receiving these communications.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples of business associates include accreditation agencies, management consultants, quality assurance reviewers, and billing and collection services. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, we require our business associates to sign a contract or written agreement stating that they will appropriately safeguard your health information.

Special Situations That Do Not Require Your Authorization

Organ and Tissue Donation: We may release health information to organizations that handle organ, eye or tissue procurement or transplantation.

Research That Does Not Require Individual Authorization: FocusHealth follows applicable federal and California law and established procedures meant to ensure your safety and privacy. We may disclose your protected health information to researchers when an Institutional Review Board ("IRB") has determined, that there is minimal risk to you, and your express consent is not required.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs if you have a work-related injury. These programs provide benefits to you for your work related injuries.

Averting a Serious Threat to Health or Safety: When necessary, we may use and disclose health information about you to prevent a serious threat to your health or safety or to the health and safety of another person or the public.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Public Health Activities: We may disclose health information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child and adult abuse or neglect
- To report reactions to medications, problems with products or other adverse events
- To notify people of recalls of products they may be using
- 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

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement: We may disclose health information if asked to do so by law enforcement officials for the following reasons:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness or missing person
- To identify the victim of a crime if, under certain circumstances, we are unable to obtain the person's authorization
- To release information about a death we believe may be the result of criminal conduct
- To provide information about criminal conduct at our facility
- In emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death of a person. We also may release health information about patients at our facility to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the correctional institution or the law enforcement official. This is necessary for the correctional institution to provide you with health care, to protect your health and safety and the health and safety of others, and to protect the safety and security of the correctional institution.

Legal Requirements: We will disclose health information about you without your permission when required to do so by federal or California law.

With Your Verbal Agreement

Individuals Involved in Your Care or Payment for Your Care: With your verbal agreement, we may disclose health information about you to a family member or friend who is involved in your medical care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status and location.

Situations Requiring Your Written Authorization

If there are reasons we need to use your information that have not been described in the sections above, we will obtain your written permission. This permission is described as a written "authorization." If you authorize us to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons stated in your written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care we provide to you. Some typical disclosures that require your authorization are:

Special Categories of Treatment Information: FocusHealth follows applicable federal and California privacy laws. Except where required or permitted by those laws, we will only release the following types of information with your (or your representative's) written signature:

- disclosures of drug and alcohol abuse treatment,
- Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) test results, and
- mental health treatment.

Research That Requires Individual Consent: Except as provided by law, we may disclose your health information to researchers only after you have signed a specific written authorization. In addition, an Institutional Review Board (IRB) will already have reviewed the research proposal, established appropriate procedures to ensure the privacy of your health information and approved the research. You do not have to sign the authorization. However, if you refuse, you cannot be part of the research study and may be denied research-related treatment.

Marketing: Under most circumstances, we will obtain your authorization for FocusHealth related marketing activities. Exceptions include direct face-to-face communication, if we give you a gift that is of nominal value, or if the marketing activity is to provide you with information about FocusHealth's treatment options or services.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you. You may contact a health information representative where services were provided to obtain additional information and instructions for exercising the following rights.

You have the right to:

1. **Obtain a copy of FocusHealth Notice of Privacy Practices**.

2. **Request a restriction on certain uses and disclosures of your information**. This request must be in writing. We are not required to agree to your request. We will not agree to any requests if it would affect your quality of care or if we are not able to do so. If we agree to your request, we will comply with your request unless the information is needed to provide you with emergency treatment. In addition, if you pay for services or a healthcare item out-of-pocket and in full, you may request that we not disclose that information for the purpose of payment or our operations with your health insurer. We can only address requests for FocusHealth affiliated entities. Your request will not extend to a physician's private practice.

3. **Inspect and request a copy of your health record**. This request for inspection or copies must be in writing and directed to the FocusHealth entity where services were provided. A reasonable fee for copies will be charged. We may deny your request under limited circumstances. If you are denied access to health information, you may request that the denial be reviewed by another health care professional chosen by someone on our health care team. FocusHealth will abide by the outcome of that review.

4. **Request an amendment to your health record if you feel the information is incorrect or incomplete**. Your request must be made in writing and it must include a reason that supports the request. We may deny your request if the information was not created by our health care team, if it is not part of the information kept by our entity, if it is not part of the information which you are permitted to inspect and copy, or if the information is accurate and complete as stated. **Please note:** If we accept your request for amendment, we are not required to delete any information from your health record.

5. **Obtain an accounting of disclosures to others of your health information**. The accounting will provide information about disclosures made for purposes *other than* treatment, payment, health care operations, disclosures excluded by law or those you have authorized.

6. **Request confidential communications.** You have the right to request that we communicate with you about health issues in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. We will accommodate all requests that are reasonable based on our system capabilities. Your request must be in writing and specify the exact changes you are requesting.

7. **Revoke your authorization.** You have the right to revoke your authorization for the use or disclosure of your health information except to the extent that action has already been taken.

8. **Complain about any aspect of our health information practices to us or to the United States Department of Health and Human Services.** If you have complaints or concerns about this notice or how FocusHealth handles your health information, you should contact the FocusHealth Compliance, 8695 Spectrum Center Blvd., San Diego, CA 92123. There will be no retaliation against you if you file a complaint with FocusHealth. You also may submit a formal complaint in writing to the Office of Civil Rights, Department of Health and Human Services.

FocusHealth Affiliated Entities

Sharp HealthCare
Sharp Community Medical Group
Sharp Memorial Hospital

BILL OF RIGHTS

The FocusHealth Medical Group Member has the right to:	**The Member has the responsibility to:**
1. Exercise these rights without regard to gender, sexual orientation or cultural, economic, educational, or religious background.	1. Be familiar with the benefits and exclusions of the member's health plan coverage.
2. Be provided with information about Sharp Community Medical Group, its services, and the health care service delivery process.	2. Provide the member's health care provider with complete and accurate information.
3. Be informed of the name and qualifications of the health care provider who has primary responsibility for coordinating the member's care; and be informed of the names, qualifications, and specialties of other physicians and non-physicians who are involved in the member's care.	3. Be on time for all appointments and notify the health care provider's office for appointment cancellations or rescheduling.
4. Have 24-hour access to the member's health care provider (or covering physician).	4. Report changes in the member's condition according to health care provider instructions.
5. Receive complete information about the diagnosis, proposed course of treatment or procedure, alternate courses of treatment or non-treatment, the clinical risks involved in each, and prospects for recovery in terms that are understandable to the member, in order to give informed consent or to refuse that course of treatment.	5. Inform health care providers of member's inability to understand the information given to them.
6. Actively participate in decisions regarding the member's health care a treatment plan. To the extent permitted by law, this includes the right to refuse any procedure or treatment. If the recommended procedure or treatment is refused, an explanation will be given addressing the effect that this will have on the member's health.	6. Carry out the treatment plan that has been developed and agreed upon by health care provider and the member.
7. Be treated with respect and dignity.	7. Contact the member's health care provider or covering physician for any care that is needed after that physician's normal office hours.
8. Receive considerate and respectful care with full consideration of the member's privacy.	8. Treat the health care provider and staff with respect.
9. Receive confidential treatment of all information and records associated with member's care.	9. Obtain an authorized referral from the member's health care provider for a visit to a specialist and/or receipt of any specialty care.
10. Express opinions or concerns about the health care provider or the care provided, and offer recommendations to FocusHealth.	10. Be familiar and comply with the health care provider delivery system regarding access to routine, urgent, and emergent care.
11. Be informed of the member grievance and appeal process.	11. Have all of these responsibilities apply to the person who has the legal responsibility to make health care decisions for the member.
12. Change health care provider by contacting FocusHealth.	12. Respect the rights, property and environment of the health care provider's office.
13. Receive reasonable continuity of care and be given timely and sensible responses to questions and requests made for service.	
14. Be informed of continuing health care requirements following office visits, treatments, procedures, and hospitalizations.	
15. Have all members' rights apply to the person who has the legal responsibility to make health care decisions for the member.	