David H. Nguyen, M.D.

Diplomate American Board of Internal Medicine

27830 Bradley Road, Sun City, CA 92586 Phone: (951) 679-2358 Fax: (951) 672-8599

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health, symptoms, examination and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **NOTICE OF INFORMATION PRACTICES** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. Prior to implementation, a copy of any revised notice will be mailed to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

Sun City Medical Partners

☐ David H. Nguyen, M.D. ☐ Thang (Tim) D. Nguyen, M.D.

27830 Bradley Road
Sun City, CA 92586
Telephone: (951) 679-2358

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____ Re: _____

_____ DOB: _____

_____ Date: _____

I authorize the use or disclosure of my health information as described below. The above-listed individual or organization is authorized to make the disclosure.

The type and amount of information to be used or disclosed is as follows:

____ Problem list
____ Medication list
____ List of allergies
____ Emergency room records
____ Immunization record
____ All history and physical information
____ Entire record
____ PCP notes last 1 year
Specialist notes last 1 year
Lab results last 1 year
Radiology reports last 3 years

____ Laboratory results from _____ to _____
____ X-ray and imaging reports from _____ to _____
____ Consultation reports from _____ to _____
____ Drug and alcohol treatment
____ Psychotherapy records/mental health records
____ All discharge summaries and admission records
____ Other _____

PLEASE MAIL RECORD TO OUR OFFICE

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may also include information above behavioral or mental services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following individual or organization:
Name: SUN CITY MEDICAL PARTNERS ATTN: DR. NGUYEN
Address: 27830 BRADLEY ROAD, SUN CITY CA 92586
For the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provided my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that the entity or person releasing records will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. I understand that the information used or disclosed as a result of this Authorization may be subject to re-disclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provide in CFR 164-524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my HIM director or privacy officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Sun City Medical Partners

27830 Bradley Road, Sun City, CA 92586 Phone: (951) 679-2358 Fax: (951) 672-8599

David H. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Thang (Tim) D. Nguyen, M.D.
Diplomate American Board of Internal Medicine

GUARANTEE OF FINANCIAL RESPONSIBILITY FOR PROFESSIONAL SERVICES

I understand that any eligibility for benefit coverage of professional and other services by my health plan is not a guarantee of payment for services rendered to me.

I wish to receive medical services from Sun City Medical Partners at this time.

In the event I am ineligible for benefits from a health plan I understand that I will be fully/personally responsible for all services and supplies provided to me. I will pay all such charges when I am presented with a bill.

In the event I have no health insurance coverage or I refuse to guarantee the financial responsibility, I understand I must pay for all services rendered at the time of service.

Patient Name: _____ Date of Birth: ____ / ____ / ____

Signature: _____ Today's Date: ____ / ____ / ____

Sun City Medical Partners

27830 Bradley Road, Sun City, CA 92586 Phone: (951) 679-2358 Fax: (951) 672-8599

David H. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Thang (Tim) D. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Advance Directive Status

I have been informed of my right to formulate an Advance Directive and I have been provided with information regarding the execution of an Advance Directive.

Please check one of the following:

☐ I have previously completed an Advance Directive and have provided a copy for inclusion in my record.

☐ A copy of my Advance Directive is on file with _____.
(Physician or health care facility)

☐ I have not executed and Advanced Directive and I am not interested in any further information.

☐ I am interested in the formulation of an Advance Directive and will discuss my options with my primary care provider.

Patient Name: _____ Date of Birth: ____ / ____ / ____

Signature: _____ Today's Date: ____ / ____ / ____

Sun City Medical Partners

27830 Bradley Road, Sun City, CA 92586 Phone: (951) 679-2358 Fax: (951) 672-8599

David H. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Thang (Tim) D. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Dear Patient:

When one of our patients has any type of laboratory test, x-ray or pathology results pending, and has not heard from us, Sun City Medical Partners request that the patient calls our office for these results.

If you have not heard from us within ***2 weeks*** of taking your test, ***do not assume your results are normal.***

We feel that you should know your results, and that ***you*** take responsibility to make sure you know they have been reviewed.

If abnormal test results are found, we plan to inform you. At times however, the results are sent to the wrong physician and not to our office. By participating in your care and assuring that you know the tests taken have been received and reviewed by the physician personally, we can act together as a team to achieve the highest quality health care.

I have been informed and understand that I am responsible for making sure my test results have been received/reviewed by my doctor.

Patient/Responsible Party: _____ Date: ____ / ____ / ____

Witness: _____ Date: ____ / ____ / ____

Sun City Medical Partners

27830 Bradley Road, Sun City, CA 92586 Phone: (951) 679-2358 Fax: (951) 672-8599

David H. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Thang (Tim) D. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Adult TB Exposure Risk Assessment

(Evaluation questionnaire to determine if Mantoux Tuberculin Skin Test (TST) is indicated)

Name: _____ Age: _____ Date of Birth: _____ / _____ / _____

The health care worker is to ask the following questions during each periodic health assessment:

1.	Have you or anyone you see regularly been diagnosed of suspected of being sick with active disease?	☐ Yes	☐ No
2.	Do you have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?	☐ Yes	☐ No
3.	Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of 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 condition(s)?	☐ 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 been 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

INSTRUCTIONS TO HEALTH CARE WORKER:

Administer the Mantoux TB skin test to all adults who have any of the above risk facts (indicated by a YES response) UNLESS

1. The patient has previously **DOCUMENTED*** positive Mantoux TST, or
2. The patient has had a TST within the last year.

Note: Trained medical personnel must read the skin test.

***DOCUMENTED** record indicating date of Mantoux and the millimeter results.

Health Care Worker completing form: _____ Date: _____ / _____ / _____

Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.				Interventions Code/Date/Initials
Do You:				
11. Smoke cigarettes or cigars or use any other kinds of tobacco?	☐ Yes	☐ No	☐ Skip	
12. Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight?	☐ Yes	☐ No	☐ Skip	
13. Often have more than 2 drinks containing alcohol in one day?	☐ Yes	☐ No	☐ Skip	
14. Think you or your partner could be pregnant?	☐ Yes	☐ No	☐ Skip	
15. Think you or your partner could have a sexually transmitted disease?	☐ Yes	☐ No	☐ Skip	
Have You:				
16. Or your partner(s) had sex without using birth control in the last year?	☐ Yes	☐ No	☐ Skip	
17. Or your partner(s) had sex with other people in the past year?	☐ Yes	☐ No	☐ Skip	
18. Or your partner(s) had sex without a condom in the past year?	☐ Yes	☐ No	☐ Skip	
19. Ever been forced or pressured to have sex?	☐ Yes	☐ No	☐ Skip	
20. Ever been hit, slapped, kicked, or physically hurt by someone?	☐ Yes	☐ No	☐ Skip	
21. Do you have other questions or concerns about your health? (Please identify) _____ _____ _____ _____ _____	☐ Yes	☐ No	☐ Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

"STAYING HEALTHY" ASSESSMENT
Adults, 18 years of age and older

Patient Name: _____
Last First M.I.

Sex: ☐ Male ☐ Female Date of Birth: ____ / ____ / ____ Today's Date: ____ / ____ / ____

You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (√) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.				*For Clinical Use* Assistance needed: Reading: ☐ Yes ☐ No Interpreter: ☐ Yes ☐ No Annual Review Date/Initials
Sample Question and Answer: Do you play sports?	☐ Yes	☐ No	☐ Skip	Interventions Code/Date/Initials
Do You:				
1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	☐ Yes	☐ No	☐ Skip	
2. See dentist at least once a year?	☐ Yes	☐ No	☐ Skip	
3. Drink milk or eat yogurt or cheese at least 3 times each day?	☐ Yes	☐ No	☐ Skip	
4. Eat fruits and vegetables every day?	☐ Yes	☐ No	☐ Skip	
5. Try to limit the amount of fried or fast foods that you eat?	☐ Yes	☐ No	☐ Skip	
6. Exercise or do moderate physical activity suck as walking or gardening 5 days a week?	☐ Yes	☐ No	☐ Skip	
7. Think you need to lose or gain weight?	☐ Yes	☐ No	☐ Skip	
8. Often feel sad, down or hopeless?	☐ Yes	☐ No	☐ Skip	
9. Have friends or family members that smoke in your home?	☐ Yes	☐ No	☐ Skip	
10. Often spend time outdoors without sunscreen or other protection suck as a hat or shirt?	☐ Yes	☐ No	☐ Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

Sun City Medical Partners

27830 Bradley Road, Sun City, CA 92586 Phone: (951) 679-2358 Fax: (951) 672-8599

David H. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Thang (Tim) D. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Dear Patients,

To assist our practice meet Medicare/Government Regulations; we would appreciate your answer to the following questions:

Patient Name: _____ Date of Birth: ____ / ____ / ____

TOBACCO USE

Tobacco Use: ☐ Current ☐ Former ☐ Never

Type: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing Tobacco

Packs/Units per Day: _____

Ever tried to quit: No / Yes Year Quit: _____

RACE

- ☐ African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other
- ☐ Patient declines to provide information

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to provide information

PRIMARY LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Korean
- ☐ Vietnamese
- ☐ Chinese
- ☐ Other
- ☐ Patient declines to provide information

RELIGION

- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jew
- ☐ Catholic
- ☐ Muslim
- ☐ Other
- ☐ Patient declines to provide information

Thank you for your cooperation!
Sun City Medical Partners

PATIENT HEALTH HISTORY

Name: _____ Date: ____ / ____ / ____

Age: _____ Date of Birth: ____ / ____ / ____ Date of last physical examination: ____ / ____ / ____

What is your reason for the visit? _____

CONDITIONS

☐ AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infection
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal Disease

ALLERGIES

Please list any allergies to the following: medications, foods or other

_____ _____

_____ _____

_____ _____

FAMILY HEALTH HISTORY

Relation	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

SURGERIES

_____

I certified that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ Date: ____ / ____ / ____

Reviewed By: _____ Date: ____ / ____ / ____

Acknowledgement of Receipt of Notice of Privacy Practices

Sun City Medical Partners
27830 Bradley Road
Sun City, CA 92586

Privacy Officer: Practice Manager (951) 679-2358 Effective Date: August 12, 2013

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physicians. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Patient's Signature: _____ Date: _____ / _____ / _____

Print Name: _____ Phone Number: (_____) _____ - _____

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name: _____ Relation to Patient: _____

Communication of Personal Health Information:

General office policy is that no information may be left with anyone but the patient. Many patients may find multiple methods of communication acceptable, even though total confidentiality cannot be guaranteed.

Below is a list of Communication Options. Please place a check mark next to the methods that are acceptable means of communicating information regarding your health. Please understand that a check mark grants us permission to **COMMUNICATE ANY AND ALL INFORMATION TO YOU IN THIS MANNER.**

Home Answering Machine/Voice Mail	☐ Acceptable
Office Voice Mail	☐ Acceptable
Cell Phone/Voice Mail	☐ Acceptable
Message with Spouse/Designated Family Member	☐ Acceptable

Name	Relationship	Phone Number

Notice of Privacy Practices Acknowledgment Tracking Information

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain: _____

Reasons for refusal: _____

Employee Name: _____ Date: _____ / _____ / _____

Sun City Medical Partners

27830 Bradley Road, Sun City, CA 92586 Phone: (951) 679-2358 Fax: (951) 672-8599

David H. Nguyen, M.D.
Diplomate American Board of Internal Medicine

Thang (Tim) D. Nguyen, M.D.
Diplomate American Board of Internal Medicine

EMERGENCY CONTACT INFORMATION:

Patient Name: _____ Date of Birth: ____ / ____ / ____

In case of emergency please contact the following:

1. Name: _____ Relationship: _____

   Address: _____

   Phone Number: _____ Alternate Number: _____

2. Name: _____ Relationship: _____

   Address: _____

   Phone Number: _____ Alternate Number: _____

3. Name: _____ Relationship: _____

   Address: _____

   Phone Number: _____ Alternate Number: _____

PATIENT ACCOUNT INFORMATION

PATIENT

Patient Name: _____ ☐ Male ☐ Female
Last First M.I.

Address: _____
Street City State Zip Code

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth: _____ / _____ / _____ DL or ID: _____

Patient Email Address: _____ Social Security Number : _____ - _____ - _____

Employer Name: _____ Occupation: _____

Employee Address: _____ Employer Phone: (_____) _____ - _____

SPOUSE OR GUARDIAN

Spouse or Guardian: _____ ☐ Male ☐ Female
Last First M.I.

Address: _____
Street City State Zip Code

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Date of Birth: _____ / _____ / _____ DL or ID: _____

Patient Email Address: _____ Social Security Number : _____ - _____ - _____

Employer Name: _____ Occupation: _____

Employee Address: _____ Employer Phone: (_____) _____ - _____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: _____ ☐ HMO ☐ Medicare ☐ PPO ☐ Private

Address: _____
Street City State Zip Code

Policy or Identification Number: _____ Effective Date: _____ / _____ / _____

Medicare Number: _____ Medical Number: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: _____ ☐ HMO ☐ Medicare ☐ PPO ☐ Private

Address: _____
Street City State Zip Code

Policy or Identification Number: _____ Effective Date: _____ / _____ / _____

Medicare Number: _____ Medical Number: _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits/coverage and tests ordered by my doctor may NOT be covered**. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that out charges will be paid by the Insurance Company. Insurance is an agreement between you and you insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient's Signature: _____ Date: _____ / _____ / _____

A13. Coroners: We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths. A14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

A15. Public safety: We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

A16. Specialized government functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

A17. Worker's compensation: We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

A18. Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization at any time by written request.

C. Your Health Information Rights

C1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

C2. Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. We will attempt to comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. However, we utilize a variety of automated systems which may restrict our ability to comply with certain requests. For example, patient statements from our automated billing system will always be sent to your home address.

C3. Right to Inspect and Copy: You have the right to inspect and have a copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

C4. Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

C5. Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs A1 (treatment), A2 (payment), A3 (health care operations), A6 (notification and communication with family) and A16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

C6. You have a right to a paper copy of this Notice of Privacy Practices: If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed below. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services (DHHS) in Washington DC. You will not be penalized for filing a complaint.

Privacy Officer: Practice Manager (951) 679-2358

Effective Date: August 12, 2013

Sun City Medical Partners
27830 Bradley Road
Sun City, CA 92586

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed on back.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

A1. Treatment: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

A2. Payment: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may disclose information to our billing service and to other health care providers to assist in obtaining payment for services they have provided to you.

A3. Health Care Operations: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you to all the other health care providers and health plans who participate in any managed health care operations affiliated with this medical practice.

A4. Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

A5. Sign in sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you. Others who sign in may see your name.

A6. Notification and communication with family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communicating with your family and others.

A7. Marketing: We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. This may include promotional items with a small value. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

A8. Required by law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the minimum relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

A9. Public health: We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

A10. Health oversight activities: We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

A11. Judicial and administrative proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process.

A12. Law enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

WELCOME

Welcome to Sun City Medical Partners (SCMP). The physicians and staff here at SCMP look forward to establishing a healthy medical relationship with you.

OFFICE HOURS: 8:00am to 12:00pm and 1:00pm to 5:00pm, Fridays close at 4:30pm

DIRECTIONS: We are located near the intersection of Bradley and McCall, next to the fire station.

PRIOR TO YOUR FIRST VISIT:
Please read, complete and bring the enclosed forms, along with your insurance card, with you for your first visit. If you do not bring the completed information, your appointment may be delayed while you fill the forms out. Plan to arrive 15 minutes before your scheduled appointment time. If available, please also bring the following:

1. Copies of any medical history and lab work
2. List of your present medications and dosage amount.

APPOINTMENTS/ CANCELLATIONS:
Please call (951) 679-2358 at least 24 hours prior to your appointment time to cancel or reschedule **to avoid a $25 rescheduling fee.** We appreciate your courtesy in cooperating with our request.

LABORATORY RESULTS:
You will receive a call from the assistant or the doctor with your results within 5-7 days. If you have not heard from us within 2 weeks, please call for your test results.

REFERRALS:
Please allow us 24 hours to process your referral request. You will receive a call from the nurse between 7-10 working days. Once the nurse calls you, please wait 24 hours before calling the doctor's office you are being referred to for an appointment.

PHARMACY REFILLS:
Prescriptions that will need to be refilled prior to your next visit should be discussed with the doctor at the time of your appointment. Between appointments prescriptions may be refilled by having your pharmacist fax us a request to (951) 672-8599 during regular office hours. We will process your request within 24-48 hours of receiving the fax. Please make sure you request your medications at least 48 hours in advance prior to running out of them.

MESSAGES TO YOUR DOCTOR:
All calls will be answered by the end of the day unless your doctor is out of the office. Please let us know if you are calling with a physical problem that needs immediate attention.

AFTER HOURS:
A Physician is on call after hours and weekends for emergencies. Your doctor can be reached by calling the SCMP office phone number: (951) 679-2358.

COPYING OF MEDICAL RECORDS:
There is a $15 - $25 charge for each copy of your medical record. Please send your signed request along with cash or check, payable to Dr. Nguyen.

Thank you for choosing Sun City Medical Partners; we look forward to serving you for your medical care.