Jerry Fabrikant DPM, Inc. - 5565 Grossmont Center Dr Bldg 3 Ste 353

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, ____________________________ have been informed of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

____

____

____

Jerry Fabrikant DPM, Inc.

Request for Access to Protected Health Information

Name: ________________________________ Date of Birth:_________

Request for Access

_____ I would like to access and inspect my Protected Health Information ("PHI").

_____ I would like Jerry Fabrikant DPM, Inc. to send a copy of my PHI to:.

Name:_______________________________________.

Address: _____________________________________.

Phone: ___________ Fax: ___________.

_____ I would like a summary of my requested PHI..

Description of Records or Information to Access, Copied, or Inspected:

____

____

Inspection Period:

I request information regarding the following time period:

From: _______/________/_________/ To: _______/________/_________/

Month / Day / Year Month / Day / Year

Copy Fees

I understand that Jerry Fabrikant DPM, Inc. may charge me for making copies of my PHI. Jerry Fabrikant DPM, Inc. may charge me 25 cents per page of PHI photocopied.

Your Rights Regarding This Request

- I understand that I must be provided with a signed copy of this document.
- I understand that Jerry Fabrikant DPM, Inc. may deny my request to access my PHI, in whole or in part.

If I am denied access, I may request a review of their decision by submitting a Request for Review of Denial of Access. Jerry Fabrikant DPM, Inc. will designate another health care professional, who was not directly involved in the decision to deny access, to conduct a second review of my request.

Signature:____Date: _________

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name:______________________________________Relationship:________________

Jerry Fabrikant DPM, Inc.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

First Name: ______________________________ Date: ________________

Last Name: ______________________________ DOB: ________________

I authorize Jerry Fabrikant DPM, Inc. to release my medical records to:

Name: ____

Address: ____

City: ______________________ State: ______________ Zip Code:______________

Telephone: ______________________________ Fax: ______________________

I authorize Jerry Fabrikant DPM, Inc. to release my medical records to:

€ All medical sources, including any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf

Please release the following documentation:

€ Complete Chart
€ Discharge Summaries
€ Consultations
€ Lab Work
€ X-Rays
€ Skin Tests
€ Other: ______________________________

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Patient Signature:__________________________ Date: ________________

AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

__________ First Request __________ Second Request __________ Third Request

Jerry M. Fabrikant, D.P.M., Inc.
Treatment of the Foot and Ankle
Worker's Compensation, QME

Patient Information Form

Date:____________________

PATIENT INFORMATION:
Last Name: __________________ First Name: ________________ Mid. Initial: ___
Home Address: ____
Street City State Zip
Home Phone: _____________ Cell: _______________ Work Phone: ___________
Email: ______________________________
Date of Birth: ___________ Age: _____ SSN: _____ - ___ - _____ Gender: M F
Marital Status: M D S W SEP Weight: _______ Height:_______
Preferred Language: ___________ Ethnicity: _____________ Race: _____________
Is this a work related injury?: Yes No If so: Date of Injury____________________

SOCIAL HISTORY:
Have you smoked in the past? Yes No Do you smoke now?: Yes No
How many packs a day? ____ Do you drink alcohol? Yes No
How many drinks per day? ____ Do you drink caffeine? ____ How much? _____

MEDICAL HISTORY:
Please list all **allergies**

____

____

____

Please **circle** any of the conditions that you have: Anemia, Arthritis, Asthma, Cancer, Diabetes, Drug Abuse, Epilepsy, Gout, Heart Disease, Ulcers, Tuberculosis, Kidney or Reproductive Problems, Psychiatric Care, Rheumatic Fever, Urinary Tract Problems.

PLEASE SIGN AND RETURN TO FRONT DESK

I hereby authorize Dr. Fabrikant to furnish to the above insurance company(s) or to the designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign to Dr. Fabrikant all monies to which I am entitled for medical and/or surgical expenses relative to the service rendered by him, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that money received from the above names insurance company(s), over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this assignment. ***In the event of non-payment, a finance charge of 1% per month (12% A.P.R.) will be applied to the outstanding balance.*** I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

______________________________ ______________________________

PATIENT'S SIGNATURE **INSURED OR GUARDIAN'S SIGNATURE**

I am aware that if I do not provide a 24-hour notice to cancel my appointment, I am subject to a $25.00 "NO SHOW" Fee.

______________________________ ______________________________

PATIENT'S SIGNATURE **INSURED OR GUARDIAN'S SIGNATURE**

Medication List Name______________________________ Date of Birth_______________

	Name	Dosage
1.	___________________________	___________
2.	___________________________	___________
3.	___________________________	___________
4.	___________________________	___________
5.	___________________________	___________
6.	___________________________	___________
7.	___________________________	___________
8.	___________________________	___________
9.	___________________________	___________
10.	___________________________	___________
11.	___________________________	___________
12.	___________________________	___________
13.	___________________________	___________
14.	___________________________	___________
15.	___________________________	___________

Jerry Fabrikant DPM, Inc.
5565 Grossmont Center Dr
Bldg 3 Ste 353
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Lamesa
California, 91942

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Jerry Fabrikant DPM, Inc. understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 01/30/2017, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time; your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice We may disclose your health information to a family member, friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of

(including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a

summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Bridgett MacDonald
Telephone: 6194653443
E-mail: drjerryfabrikant@gmail.com
Address: 5565 Grossmont Center Dr Bldg 3 Ste 353
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Zip Code: 91942
State: California
City: Lamesa