Adult Patient Registration

Patient Information

Name: ____ Date of Birth: __________________________

Home Address: ______________________________________ City, State Zip: ____________________________

Names & Ages of Immediate Family Members (e.g., Jack, 9): ____

____

Primary Email: ____ Primary Phone: (____) __________________

Home Pharmacy Information

Pharmacy Name: ______________________ Address, City, State Zip: __________________________________

Telephone: (______) ______________________________ Fax: (______) ______________________________

Insurance Information *(Please bring insurance cards to each visit.)*

Primary Insurance Plan: __________________________________ Member ID: ________________________

Guarantor/Primary Subscriber's Name: __________________________ Effective Date: ____________________

Relationship to Patient: _______________________________________ Date of Birth: ____________________

Email Address: ____________________________________Primary Phone: (_____) ______________________

I understand that payment of all medical care is due at the time of service. I am responsible for all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Growing Health Together to release any pertinent information to my insurance company upon request. By signing below, I authorize Growing Healthy Together to provide me with medical services and to seek reimbursement for those services. A photocopy of this authorization shall be considered as effective and valid as the original.

Guarantor/Primary Subscriber Signature: __________________________________ Date: __________________

Secondary Insurance Plan: _______________________________ Member ID: ________________________

Guarantor/Primary Subscriber's Name: __________________________ Effective Date: ____________________

Relationship to Patient: _______________________________________ Date of Birth: ____________________

Email Address: ____________________________________Primary Phone: (_____) ______________________

I understand that payment of all medical care is due at the time of service. I am responsible for all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Growing Health Together to release any pertinent information to my insurance company upon request. By signing below, I authorize Growing Healthy Together to provide me with medical services and to seek reimbursement for those services. A photocopy of this authorization shall be considered as effective and valid as the original.

Guarantor/Primary Subscriber Signature: __________________________________ Date: __________________

Adult Health History

Name: ____ Pronouns used: ____________________________

Date of Birth: _____________________ Sex assigned at birth: Female Male Other: __________________________

Current gender identity (*Choose all that apply*):

	Male
	Female
	Transgender male/transgender man/female-to-male (FTM)
	Transgender female/transgender woman/male-to-female (MTF)
	Genderqueer (neither exclusively male nor female)
	Other: ____
	Choose not to disclose

Sexual Orientation (*Choose all that apply*):

	Straight or heterosexual
	Lesbian, gay, or homosexual
	Bisexual
	Other: ____
	Don't Know
	Choose not to disclose

Medical History: None

Major Illnesses (e.g., high blood pressure, depression, diabetes)	**Year of Diagnosis**	**Current Treatment**

Surgical History: None

Surgeries (e.g., c-section, appendectomy, LASIK eye surgery)	**Year of Surgery**	**Reason for Surgery**

Surgical complications? Yes No If yes, describe: ____

Date of last lab work: ____________________ List any abnormal levels: ____

Immunizations

	Date of last vaccine		**Date of last vaccine**
Tetanus (Td or Tdap)		Influenza	
MMR (measles, mumps, rubella)		Varicella	
Pneumococcal		Zoster (shingles)	
Meningococcal		Hib	
Hepatitis A		Polio	
Hepatitis B		HPV	
COVID-19		Other:	

Current Medications: None (***Please bring all medications to appointments.)***

Medication	Dose	Frequency

Do you take any vitamins or supplements? Yes No If yes, which? ____________________________________

____

Allergies: None

Food allergies: ____

Medication allergies: ____

Other allergies: ____

Are you currently pregnant/nursing? Yes No Number of pregnancies: _______ Number of deliveries: _______

Date of last Pap test: _____________________ Normal? Yes No

Date of last menstrual period: _____________________ Normal? Yes No

Date of last mammogram: _____________________ Normal? Yes No

Date of last prostrate exam: _____________________ Normal? Yes No

Habits

Hobbies/Interests: ____

Do you spend time outdoors? Yes No Do you exercise? Yes No

What form of exercise? _________________________________ Number of days per week: _____ Hours per week: ______

Do you get an averae of 6-8 hours of sleep per night? Yes No Do you feel that you sleep well? Yes No

Are you sexually active? Yes No Not currently Birth control method: ____________________________________

Have you ever had any sexually transmitted infections (STIs)? Yes No If yes, which? __________________________

Do you or have you used tobacco? Yes No If yes, for how many years? ________________________________

Packs per day: ________ What year did you quit? _______ Are you exposed to smoke at home or work? Yes No

Do any smokers live in the house? Yes No If yes, do people smoke inside or outside? _________________

Do you or have you consumed alcohol? Yes No If yes, how many drinks per week? __________________________

What type of alcohol do you drink (i.e., beer, wine, whiskey, vodka)? ____

Do you or have you consumed marijuana? Yes No If yes, for how many years? ________________________

How do you consume marijuana (e.g., smoke, tinctures, edibles)? ____

How many cups of caffeine do you drink per day? _______ Coffee Tea Cola Other: _____________________

Do you or have you used other drugs? Yes No If yes, what type? ____

For how many years? _______ What year did you quit? _______ Additional comments: ____________________________

____

Social History

Birthplace: ____

Relationship Status: Single Married Partnered Separated Divorced Widowed

Living Arrangement (*Choose all that apply*):

	Alone
	Spouse/Partner(s)
	Child(ren)
	Sibling
	Parent(s)/Guardian(s)
	Group setting
	Personal care attendant
	Other:___________________________________

Education: ____

Occupation(s) past and present: ____

Have you traveled outside the U.S. in the past year? Yes No Where and when? ______________________________

Religion: ____

Family History

	Father	Mother	Child	Spouse	Sisters	Brothers
Age (if living)						
Health (G=good,P=poor)						
Age at death (if deceased)						
Cause of death						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Epilepsy						
Mental illness (specify)						
Asthma/ hayfever/hives						
Anemia						
Kidney disease						
Glaucoma						
Tuberculosis						
Suicide						
Cancer (specify)						

What are your chief symptoms or medical problems at this time, if any? ____

____

____

Permission to Treat

I (We) ____authorize Growing Healthy Together and its personnel

print name(s)

to deliver medical services to myself **OR** my children, listed below.

Name(s) of Child(ren) (if applicable)

Name: ____ Date of Birth: ________________________

Name: ____ Date of Birth: ________________________

Name: ____ Date of Birth: ________________________

Name: ____ Date of Birth: ________________________

Name: ____ Date of Birth: ________________________

Name: ____ Date of Birth: ________________________

Emergency Contact

I (we) authorize the following people to contact in case of emergency.

For parents/guardians: I (we) authorize the following person(s) to bring my child(ren) in for treatment and/or to contact in case of emergency.

Name: ______________________________ Phone: (_____) _______________ Relationship: ________________

Name: ______________________________ Phone: (_____) _______________ Relationship: ________________

Name: ______________________________ Phone: (_____) _______________ Relationship: ________________

Name: ______________________________ Phone: (_____) _______________ Relationship: ________________

Please check one of the following:

☐ **I am an adult patient, signing on behalf of myself.**

☐ **I am a parent/guardian, signing on behalf of my child(ren), listed above.**

____ ________________________

Signature(s) Date

(______)_________________________ ____

Primary Phone Relationship to Patient (if applicable)

Financial Policy

GHT currently only accepts PPO insurance, discounted cash pay (self-pay), and concierge patients.

Insurance Coverage

Your insurance plan is a contract between you and your insurance company. It is your responsibility to understand the benefits and coverages your medical plan provides. **Growing Healthy Together and our providers are registered as in- and out-of-network providers. Your insurance plan typically covers both; however, check your specific policy for coverage amounts and details.** Bring your insurance card with you for each visit. Providing your insurance card and information does not guarantee payment from your insurance company. If we do not have your current, active insurance policy on file, you may be asked to pay at the time of service.

Cash Patients

Payment in full is required at the time of service. Exam fees do not cover add-on services like additional tests, screenings, vaccines, or procedures. Refer to our Services & Costs sheet for more information. Exceptions to this policy must be arranged with management before your visit.

New Patient Appointment Deposit

A $50 non-refundable deposit per patient is **required** for new patients to confirm and hold their appointment at the time of scheduling. If you keep your appointment, the deposit is applied to the cost of the visit or applied to a future visit. If you cancel your appointment at least 24 hours before, the deposit will be used for a future appointment. If you miss the appointment, you will lose your deposit.

Newborn Registration

You have 30 days to add your newborn to your insurance. If you do not add them within 30 days, you will be retroactively charged the total insurance cost per visit. For all future visits, you will be charged the discounted cash pay (self-pay) rate.

Consults, Preventative Care, & Sick Visits

Claims are billed based on your provider's clinical evaluation and diagnosis during exams. A preventative care appointment can become an office consultation or sick visit, resulting in copays, co-insurance, or deductibles that are the patient's responsibility to pay. For example, it will become a consult or sick visit if you require assessment, evaluation, or provider intervention during a vaccine-only appointment.

Telemedicine, Spruce Messages, and Virtual Appointments

Telemedicine, Spruce messages, and phone calls **are subject to insurance or self-pay billing**, determined by your provider's medical evaluation and clinical judgment at the time of the exam. Co-pays, co-insurance, and deductibles may apply.

Coordination of Benefit Holds (COB)

A claim may be placed on a COB hold if the insurance company needs to verify whether the patient had dual coverage at the time of service or if the insurance company requires additional information before processing the claim. If a claim is unpaid due to a COB hold, the member must clear the hold within 30 days of notification. Uncleared claim amounts due to COB holds are the patient's responsibility to pay without a guarantee of reimbursement or reprocessing by the insurance company.

Co-Pays, Deductibles, and Co-Insurance

Co-payments are due at check-in before being seen by your provider. Co-insurance and deductible amounts are determined by your contract with your insurance company. After your insurance company has processed a claim, any balances they determine are the patient's responsibility will be billed to you to be **paid within 30 days of receipt.**

Late and Missed Appointments

All appointments must be confirmed before the date of service. If you cannot make your appointment, we require a 24-hour cancellation notice. If you are running late, please notify the office. We may need to reschedule your appointment so our providers can spend adequate time with your child and other patients. **A $50 late/no-show fee per patient is charged for those who do not notify us of late arrival and appointment cancellations within 24 hours of the visit.**

Non-Covered Services

"Services" describe any interaction or service provided by an employee of GHT, including but not limited to wellness, office, sick, vaccine-only, nurse-only, and consultation visits.

Returned Check Fee

If your payment is made by e-check or paper check and the check is returned from the bank as dishonored, a **$25.00** return check fee will apply.

Transaction Fee

If a credit card payment is returned, declined, or incorrectly disputed, a **$25.00** processing fee will apply.

Form Fee

Patients often request various forms (school, disability, etc.) to be completed by GHT. Forms require review and completion of a medical history by our providers. Our documentation fee is **$25.00** and must be paid in full at the time forms are submitted. As a courtesy, we waive this fee if the patient provides forms during their scheduled visit.

Unpaid and Outstanding Balances

Full payment of all outstanding balances must be made before your next appointment unless prior arrangements have been made through our billing department. You may also set up payment arrangements through our billing department if necessary. **Overdue balances will be sent to collections**.

We offer convenient ways to pay your bill.

You can submit payments through online bill payment after creating your patient portal account. You can also mail us your payments or call our office at (562) 473- 4441 for assistance.

I understand if I have an unpaid balance to Growing Healthy Together and do not make satisfactory payment arrangements, my account will be placed with an **external collection agency**. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

For Growing Healthy Together or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Growing Healthy Together and the designated external collection agency are authorized to:

- *(i) Contact me by telephone at the telephone number (s) I am providing, including wireless telephone numbers, which could result in charges to me,*
- *(ii) Contact me by sending text messages (message and data rates may apply) or emails using any email address I provide and*
- *(iii) Contact methods may include pre-recorded/artificial voice messages and/or automatic dialing devices, as applicable.*

Furthermore, I consent to the designated external collection agency to share personal contact and account-related information with third-party vendors to communicate account-related information via telephone, text, e-mail, and mail notification.

By signing, I acknowledge that I have read and understood the policies of Growing Healthy Together described above. I agree to be personally responsible for all applicable fees.

Patient Name: ____ Date of Birth: _____________________

Parent/Guardian Name (if applicable): ____

Primary Phone: _____________________ Primary Email: ____

Signature: ____ Date: _____________________

Our Services & Costs

Office Visits (Wellness Visit, Sick Visit, Routine Visit): **$150**
Testing (Tb Test (PPD), Urine Dip, Hemoglobin/Hematocrit, & Rapid Strep A Test): **$50**
Flu Shots: **$50**
Injections: **$75**
Screenings: **$50**
Ear Lavage (One ear or both): **$75**
Silver Nitrate: **$50**
Nebulizer Treatment: **$99**
Other (Wart, Skin Tag, I & D of Abscess): **$129**

Vaccines

- DTaP: **$51.50**
- Tdap: **$74.16**
- Td: **$50**
- Polio: **$54.60**
- Rotavirus (Rotateq): **$164**
- Varicella (chickenpox): **$211.80**
- MMR (M-M-R II): **$166**
- Hib (ActHIB): **$54.08**
- MCV4: Meningococcal conjugate vaccine (Medquafi): **$242.05**
- PCV13: Pneumococcal conjugate vaccine (Prevnar): **$301.24**
- Hepatitis A (Hep A, Havrix): **$80**
- Hepatitis B (Engerix-B, Recombivax HB): **$70**
- HPV (Gardasil): **$365**

Combination Vaccines

Proquad (MMR + varicella): **$337.70**
Pentacel (DTaP, HiB, Polio): **$142.14**

Quadracel (DTaP + Polio): **$93.60**

Concierge Plan

The concierge fee is $99 per month for a one-year contract. Concierge patients are charged for each vaccine used at the VFC (Vaccines for Children Program) retail rate of $26.03 per vaccine, a statewide rate for those who qualify for the vaccine program.

Out-of-Pocket Costs

All cash-based visits are $150 per visit.

Our policies are subject to change without notice. We at GHT understand financial pressure, so we aim to keep our practice as affordable as possible. For more questions or concerns, please contact us at www.ghtkids.com/contact-us/ or by phone at (562) 473-4441.

Notice of Privacy Policies

As required by the privacy regulations created due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you, or your child (as a patient of our practice) may be used and disclosed, and how you can get access to your or your child's individually identifiable health information.

Our Commitment to Your Privacy

Growing Healthy Together is dedicated to maintaining the privacy of you or your child's individually identifiable health information (IIHI). In conducting our business, we create records regarding you or your child and the treatment and services we provide. We are required by law to maintain the confidentiality of health information that identifies you or your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning you or your child's IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose you or your child's IIHI
- You or your child's privacy rights in their IIHI
- Our obligations concerning the use and disclosure of you or your child's IIHI

The terms of this notice apply to all records containing you or your child's IIHI created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all your records that our practice has created or maintained in the past and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Site Manager, Growing Healthy Together at 562-473-4441.

We May Use and Disclose You or Your Child's Individually Identifiable Health Information (IIHI)

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment: Our practice may use you or your child's IIHI for treatment. For example, we may disclose your IIHI as follows:

- To order laboratory tests (e.g., blood or urine tests), we may use the results to help us reach a diagnosis.
- To write a prescription, we might disclose your IIHI to a pharmacy when ordering a prescription.
- To treat or to assist others in the treatment of you or your child.
- To inform you of potential treatment options or alternatives or programs, such as our Asthma Program.
- To others who you have permitted to bring your child to the office for treatment. For example, if you ask your babysitter to bring your child in to treat a cold, they may have access to your child's medical information, if applicable.
- To other health care providers for purposes related to their treatment.
- If applicable, to a parent, guardian, or other responsible people if the patient is a minor.

Payment: Our practice may use and disclose your IIHI to bill and collect payment for the services and items provided by us for you or your child. For example, we may disclose your IIHI as follows:

- To contact your health insurer to certify that your child is eligible for benefits, and we may provide your insurer with treatment details to determine if the insurer will cover, or pay for, you or your child's treatment.
- To obtain payment from other third parties that may be responsible for such costs.
- To bill you directly for services and items.
- To other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations: Our practice may use and disclose your IIHI to operate our business. As examples of how we may use and disclose you or your child's information for our operations include, but are not limited to the following:

- To evaluate the quality of care you received or conduct cost-management and business planning activities for our practice.
- To other health care providers and entities to assist in their health care operations under certain circumstances.
- To contact you and remind you of your appointment.
- To inform you of health-related benefits or services that may be of interest to you.
- When we are required to do so by federal, state, or local law.

Use and Disclosure of You or Your Child's IIHI in Certain Special Circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information to the extent such use or disclosure is required by law:

Public Health Risks: Our practice may disclose you or your child's IIHI to public health authorities that are authorized by law to collect information for:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect

- preventing or controlling disease, injury, or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

Health Oversight Activities: Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings: Our practice may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose you or your child's IIHI in response to a discovery request, subpoena, or other lawful processes by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement: We may release IIHI if required by law to do so. For example:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena, or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person

Deceased Patients: Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information for funeral directors to perform their jobs.

Research: Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your child's IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your consent satisfies the following: (i) the use or disclosure involves no more than a minimal risk to you or your child's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the Protected Health Information (PHI) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety: Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to you or your child's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization to help prevent the threat.

Workers' Compensation: Our practice may release you or your child's IIHI for workers' compensation and similar programs.

Compliance: We are required to disclose you or your child's IIHI to the Secretary of the Department of Health & Human Services or their designee upon request to investigate our compliance with HIPAA or to you upon request.

Your Rights Regarding You or Your Child's IIHI

You have the following rights regarding the IIHI that we maintain about you:

Confidential Communications: You have the right to request that our practice communicates with you about your health and related issues in a particular manner or at a specific location. For instance, you may ask us not to contact your work. To request a type of confidential communication, you must make a written request to the Site Manager, specifying the requested method or the location you wish us to contact. We will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions: You have the right to request that we limit the use and disclosure of your IIHI for treatment, payment, and health care operations. Additionally, you have the right to request that we restrict our disclosure of you or your child's IIHI to only specific individuals involved in you or your child's care, such as family members or friends. You must make your request in writing to the Site Manager. Under federal law, we must agree to your request and comply with your requested restrictions if:

- Except as otherwise required by law, the disclosure is to a health plan for payment for health care operations (and not treatment); and,
- The medical information pertains solely to a health care item or service for which provided health care has been paid out of pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is required by law or necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time if we notify you of the cancelation and continue to apply the restriction to information collected before the cancelation.

Inspection and Copies: You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you or your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Site Manager to inspect and obtain a copy of your child's IIHI. Our practice may charge a fee for the costs of

copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Site Manager. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures: All our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of you or your child's IIHI for non-treatment, non-payment, or non-operation purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your child's information to file your insurance claim. We also will not provide an accounting of disclosures made to you about your child or incident to a use or disclosure we are permitted to make as described above or according to an authorization. To obtain an accounting of disclosures, you must submit your request in writing to the Site Manager. All requests for an "accounting of disclosures" must state a period, which may not be longer than six (6) years from the date of disclosure. The first list you request within 12 months is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy at any time. To obtain a paper copy of this notice, contact the Site Manager or visit our website at www.ghtkids.com.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or the Department of Health and Human Services Secretary. To file a complaint with us, contact us at Growing Healthy Together, 3835 E 7th. St, Long Beach, CA 90804, Attn: Site Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you or your child's IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. We are required to retain records of your care.

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, explaining how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Self or Parent/Legal Guardian

Date

Print Name of Self or Parent/Legal Guardian

Legal relation to the child(ren), if applicable

List each child that is seen at our practice, if applicable (please print):

Child's First Name	Child's Last Name	Date of Birth