



# PELED PLASTIC SURGERY

## MIGRAINE HISTORY FORM

IF THIS IS YOUR FIRST VISIT, PLEASE TAKE THE TIME TO FILL THIS FORM OUT COMPLETELY.

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 E-mail address \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
 Emergency Contact Info \_\_\_\_\_  
 Emergency Contact relationship to you \_\_\_\_\_  
 Social Security#: \_\_\_\_\_ Occupation: \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax \_\_\_\_\_  
 Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Is this a litigation case? yes \_\_\_ no \_\_\_ If yes, name of attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this a Workers Compensation case? yes \_\_\_ no \_\_\_ If yes, name of case worker: \_\_\_\_\_

Are you being seen today for a particular injury or accident? yes \_\_\_ no \_\_\_ (If no, skip to past surgical history)

If so, what was the date of the injury? \_\_\_\_\_

If so, where did the injury occur (work, home, car accident)? \_\_\_\_\_

If not working now due to injury, when was your last date of work? \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

- Who is your:  
Neurologist (full name) \_\_\_\_\_  
Pain Management MD (full name) \_\_\_\_\_
- How many migraine headaches do you experience per month on average? \_\_\_\_\_
- How many regular headaches do you have per month on average? \_\_\_\_\_
- How long do your migraine headaches usually last?  
 ≤2 hrs    3-4 hrs    5-12 hrs    12-24 hrs    Several days    1 week or longer
- How painful are your migraine headaches? (Circle One Number)  
 1   2   3   4   5   6   7   8   9   10  
 Mild Severe
- Where are your migraine headaches usually located? (check all that apply)  
 behind right eye    behind left eye    behind both eyes  
 right temple    left temple    both temples  
 above right eyebrow    above left eyebrow    above both eyebrows  
 back of head on right    back of head on left    back of head on both sides
- How old were you when your migraine headaches started? \_\_\_\_\_
- How would you describe your migraine headaches? (check all that apply)  
    throbbing/pounding    ache/pressure    like a tight band    dull    other \_\_\_\_\_
- Do your migraine headaches awaken you at night? (check one)  
 never    occasionally    often
- Do any of the following occur before or during your migraine headaches?  
 nausea    vomiting    diarrhea     bothered by light/noise  
 blurred/double vision    flashing or colored lights    eyelid puffy  
 eyelid droops    loss of vision    feeling lightheaded  
 numbness/tingling    weakness of arm or leg  
 difficulty concentrating    speech difficulty    loss of consciousness  
 runny nose    other \_\_\_\_\_
- Do any of the following bring on your migraine headaches or make them worse?  
 stress (worry/anger)    bright sunshine    weather change  
 letdown after stress    loud noise    heavy lifting  
 air travel    fatigue    certain smells/perfume  
 missed meals    sexual activity  
 coughing/straining/bending    certain foods (chocolate, cheese, beer, MSG)  
 other \_\_\_\_\_
- Do any of the following make your migraine headaches better?

# PELED PLASTIC SURGERY

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> rest              | <input type="checkbox"/> exercise         | <input type="checkbox"/> quiet & darkness |
| <input type="checkbox"/> hot/cold compress | <input type="checkbox"/> massage          | <input type="checkbox"/> warm shower      |
| <input type="checkbox"/> vomiting          | <input type="checkbox"/> pressure on head |   |
| <input type="checkbox"/> other _____       |   |   |

- If you are female, do your migraine headaches change with any of the following?
 

<input type="checkbox"/> menstrual periods	<input type="checkbox"/> birth control pills	<input type="checkbox"/> quiet & darkness
<input type="checkbox"/> pregnancy	<input type="checkbox"/> other hormonal drugs	
- Do any of your family members have migraine headaches?
  - no     yes ....if "yes", who: \_\_\_\_\_
- Have you ever had a head or a neck injury requiring medical treatment?
  - no     yes .... if "yes", describe: \_\_\_\_\_
- Have you had your migraine headaches evaluated by a neurologist?
  - no     yes ....if "yes", by whom and when? \_\_\_\_\_
 What was the diagnosis? (check all that apply)
  - migraine     tension-type     cluster     other, specify \_\_\_\_\_
- List all past tests you had for your migraine headaches: \_\_\_\_\_  
\_\_\_\_\_
- List all past treatment(s) for your migraine headaches: \_\_\_\_\_  
\_\_\_\_\_
- Are you taking any prescription drugs to treat your migraine headaches?
  - no     yes ....if "yes", list the medications: \_\_\_\_\_  
\_\_\_\_\_

How often in the last month have you used these medications? \_\_\_\_\_

- Are you taking any over-the-counter drugs to treat your migraine headaches?
  - no     yes ....if "yes", list the medications: \_\_\_\_\_

How many times in the last month have you used the over-the-counter medications? \_\_\_\_\_

- How would you rate your general health in the last month? (Check One)
 

<input type="checkbox"/> excellent	<input type="checkbox"/> good	<input type="checkbox"/> fair	<input type="checkbox"/> poor
------------------------------------	-------------------------------	-------------------------------	-------------------------------
- To what extent do your migraine headaches affect your quality of life? (check one)
 

<input type="checkbox"/> extremely	<input type="checkbox"/> moderately	<input type="checkbox"/> very little	<input type="checkbox"/> not at all
------------------------------------	-------------------------------------	--------------------------------------	-------------------------------------

- What activities in life have you given up because of your headaches? \_\_\_\_\_

Do you currently have any of the following conditions?

	YES	NO		YES	NO		YES	NO
<b>EYES</b>			<b>ALLERGY</b>			<b>GENITOURINARY</b>		
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>	Pain w/ urination	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance(s)	<input type="checkbox"/>	<input type="checkbox"/>	Medication allergies (see above)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Galaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to flu vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone(s)	<input type="checkbox"/>	<input type="checkbox"/>
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to PPD	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
<b>EAR, NOSE AND THROAT</b>			Allergy to pneumovax	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to latex	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus drainage	<input type="checkbox"/>	<input type="checkbox"/>				<b>MUSCOLOSKELETAL</b>		
Nasal breathing problems	<input type="checkbox"/>	<input type="checkbox"/>				Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			<b>CARDIAC</b>			Herniated disk	<input type="checkbox"/>	<input type="checkbox"/>
Need to use oxygen at home	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack (MI)	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Back injury	<input type="checkbox"/>	<input type="checkbox"/>
<b>GASTROINTESTINAL</b>			Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<b>ENDOCRINE</b>		
Chronic nausea	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Chronic vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with pills	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac bypass	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes controlled with diet	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Black/bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEME/LYMPH</b>			<b>NEUROLOGIC</b>		
Hernia(s)	<input type="checkbox"/>	<input type="checkbox"/>	Recent lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Spleen problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>	TIA (AKA "minor stroke")	<input type="checkbox"/>	<input type="checkbox"/>

## PAST MEDICAL HISTORY:

Have you ever had any of the following?

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer (other)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please describe the condition: \_\_\_\_\_



# PELED PLASTIC SURGERY

## PAST SURGICAL HISTORY:

Please list any previous surgery with approximate dates:

Procedure	Date	Procedure	Date

## FAMILY HISTORY:

Do you have **family members** with any of the following conditions:

Breast Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Melanoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes to any of the above, please describe the condition and identify your relation to the family member: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking. If you have a long list, please provide it for us to copy.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DRUG ALLERGIES:** \_\_\_\_\_

## SOCIAL HISTORY:

Marital Status: \_\_\_\_\_ Spouse's name \_\_\_\_\_

Are you currently employed? yes \_\_\_ no \_\_\_ If so, what do you do? \_\_\_\_\_

Do you smoke? yes \_\_\_ no \_\_\_ If so, how many packs per day? \_\_\_\_\_

If you smoked in the past, when did you quit? \_\_\_\_\_

On average, how many alcoholic drinks do you have per week? \_\_\_\_\_



# PELED PLASTIC SURGERY

## **COSMETIC SURGICAL HISTORY:**

Please list any previous cosmetic surgery with approximate dates:

PROCEDURE	DATE	PROCEDURE	DATE



# PELED PLASTIC SURGERY

## OFFICE & INSURANCE BILLING AUTHORIZATION AND NOTIFICATION

By my signature below, I am authorizing PELED PLASTIC SURGERY to bill my insurance company for services provided. Occasionally, insurance companies send the insured party (yourself) reimbursement directly for medical services provided by their doctors. In such an event, any monies received directly by me for services rendered by Dr. Peled will be forwarded to this office within 2 weeks of receipt. In addition, any co-pays or deductibles will be paid in full within 2 weeks of any procedure or office visit as applicable. Finally, I understand that Dr. Peled may or may not be a participating provider with my insurance plan. As such, the allowed amount according to my insurance company for any services/procedures rendered may be less than the amount charged by PELED PLASTIC SURGERY and I acknowledge that the difference will be my responsibility. Finally, any appointments not cancelled **AT LEAST 24 HOURS** prior to the scheduled time will be subject to a \$50 cancellation fee. I further acknowledge that any questions regarding these matters have been answered by Dr. Peled and/or his staff.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

\_\_\_\_\_  
Relationship



# PELED PLASTIC SURGERY

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have been presented with a copy of Peled Plastic Surgery’s ‘Notice of Privacy Practices’ (see following pages), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of these ‘Practices’, and I request the following restriction(s) concerning the use of my personal medical information:

---

---

---

---

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

### NOTICE TO CONSUMERS

**Medical doctors are licensed and regulated by the Medical Board of California  
(800) 633-2322  
www.mbc.ca.gov**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If not signed by patient, please indicate relationship to patient (e.g. spouse)

\_\_\_\_\_  
Relationship



# PELED PLASTIC SURGERY

## **Notice of Privacy Practices**

It is the policy of this medical practice that our employees comply with our Notice of Privacy Practices, which is consistent with HIPAA and California law. Our 'Notice of Privacy Practices' is provided to all of our patients at the first encounter if possible and is also posted on our website ([www.peledplasticsurgery.com](http://www.peledplasticsurgery.com)) for viewing at any time.

### **How this Medical Practice May Use or Disclose Health Information**

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files and/or on a computer. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

#### ***Treatment***

We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share medical information with other physicians or other health care providers who will provide services we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may disclose medical information to members of patients' families or others who can help them when they are sick or injured.

#### ***Payment***

We use and disclose medical information to obtain payment for the services we provide. For example, we give health plans the information they require before they will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

#### ***Health Care Operations***

We may use and disclose medical information 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. Or we may use and disclose this information to get health plans to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share 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 this medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearing house, 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 with other health care providers, health care clearing houses or health plans that have a relationship with one our patients, when they request this information, to help them with their quality



# PELED PLASTIC SURGERY

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. From time to time, we may share health information with our professional liability carrier for our defense or their ongoing quality review of medical practice. We may also share medical information with all the other health care providers, health care clearing houses and health plans who participate in the organized health care arrangements in which we participate for any health care operations activities of these organized health care arrangements. Our manager maintains a current list of the arrangements, which include among others all relevant hospitals, IPAs and health plans in which this medical practice participates.

## ***Appointment Reminders***

We may use and disclose medical information to contact and remind our patients about appointments.

## ***Sign-in Sheet***

We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them.

## ***Notification and communication with family***

We may disclose our patients' health information to notify or assist in notifying family members, personal representatives or other persons responsible for their care about their location, general condition or in the event of 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 disclose information to someone who is involved with our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.

## ***Marketing***

We may contact our patients to give them information about products or services related to their 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 them, or to provide them with small gifts. We may also encourage them to purchase a product or service we offer when we see them. We will not otherwise use or disclose our patient's medical information for marketing purposes without their written authorization.

## ***Required by law***

As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the 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 requirements set forth below concerning those activities.

## ***Public Health***

We may, and are sometimes required by law, to disclose our patient's 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 a suspected elder or dependent adult abuse or domestic violence, we will inform our patients or their personal representatives promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

## ***Health oversight activities***

We may, and are sometimes required by law, to disclose our patients' 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.

## ***Judicial and Administrative Proceedings***

We may and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by the court or administrative order. We also may disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.

## ***Law Enforcement***

We may, and are sometimes required by law, to disclose our patients' health information to a law enforcement official for the 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.

## ***Coroners***

We may, and are often required by law, to disclose our patients' health information to coroners in connection with their investigations of deaths.

## ***Organ and Tissue Donation***

We may use and disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues.

## ***Public Safety***

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

## ***Specialized government functions***

We may disclose our patients' health information as necessary to comply with workers' compensation laws. For example, to the extent our patients' care is covered by workers' compensation, we will



# PELED PLASTIC SURGERY

make periodic reports to their employers about their conditions. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation carrier.

## **When This Medical Practice May Not Use or Disclose Health Information**

Except as described in our Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

## **Our Patients' Health Information Rights**

### ***Right to Request Special Privacy Protections***

Our patients have the right to request restrictions on certain uses and disclosures of their health information, by a written request specifying what information they want to limit and what limitations on our use or disclosure of that information they wish to have imposed. We reserve the right to accept or reject these requests, and will notify each patient of our decision.

### ***Right to Request Confidential Communications***

Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to a particular e-mail account or to their work address. We will comply with all reasonable requests submitted in writing which specify how or where they wish to receive these communications.

### ***Right to Inspect and Copy***

Our patients have the right to inspect and copy their health information, with limited exceptions. To access their medical information, they must submit a written request detailing what information they want access to and whether they want to inspect it or get a copy of it. We will respond to every written request within the time required by California and federal law. *We will charge a reasonable fee, as allowed by California and federal law in such circumstances.* We may deny the request under limited circumstances. If we deny their request to access their child's records or the records of an incapacitated adult they are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, they have a right to appeal our decision. If we deny a patient's request to access his or her psychotherapy notes, the patient will have the right to have them transferred to another mental health professional.

### ***Right to Amend or Supplement***

Our patients have the right to request that we amend their health information that they believe is incorrect or incomplete. Our patients must make the request to amend in writing, and include the reasons they believe their information is incomplete or inaccurate. We are not required to change their health information, and if we refuse, we will provide them with the information about this medical practice's denial and how they can disagree with the denial. We may deny their request if we do not have the information, if we did not create the information (unless the person or entity that created the



# PELED PLASTIC SURGERY

information is no longer available to make the amendment), if they would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning any statement or item they believe to be incomplete or incorrect.

## ***Right to an Accounting of Disclosures***

Our patients have the right to receive an accounting of disclosures of their health information made by this medical practice with the following exceptions:

- Disclosures provided to their patients pursuant to their written authorization, or as described in the paragraphs in the sections above.
- Treatment, payment, healthcare operations, notification and communication with family and specialized government functions or disclosures for purposes of research or public health which exclude direct patient identifiers.
- Disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from the agency or official that providing this accounting would be reasonably likely to impede their activities.

## ***Right to a Paper Copy of Privacy Practices***

Our patients have the right to a paper copy of this 'Notice of Privacy Practices', even if they have previously requested its receipt by e-mail.

## **Assigning Privacy and Security Responsibilities**

Our privacy official is the owner of the practice. They maintain a current list of all employees that have specific responsibilities.

## **Minimum Necessary Use and Disclosure of Protected Health Information**

It is the policy of this medical practice that all routine and recurring uses and disclosures of PHI (except for uses and disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance such as uses and disclosures of protected health information) must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of this medical practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.