STOCKTON PULMONARY DOCTORS
1801 E MARCH LANE, STE. C300
STOCKTON, CA 95210

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ **M** ☐ **F** ☐
Last First M.I.
Date of Birth: ___/___/_____ **Social Security #:** _____-____-_____ **Driver License #:** _____

Race: **American Indian/Alaska Native** ☐ **Asian** ☐ **Native Hawaiian** ☐ **Black/African American** ☐
White ☐ **Hispanic** ☐ **Other Pacific Islander** ☐ **Other Race** ☐**:** _____

Ethnicity: **Hispanic** ☐ **Non-Hispanic** ☐ **Primary Language Spoken:** **English** ☐ **Other** ☐**:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: **Home:** _____ **Cell:** _____ **Work:** _____

Email Address: _____

Employer: _____ **Occupation:** _____

Spouse/Partner Name: _____ **Phone #:** _____

Check here if: **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Other** ☐ _____

Pharmacy Name: _____ **Address:** _____ **Phone #:** _____

Referred By: _____ **Primary Care Physician:** _____

Reason for Appointment: _____

Advanced Directive: **Yes** ☐ **No** ☐ **(paperwork available upon request)**

INSURANCE INFORMATION

***Primary Insurance:** _____ **Subscriber Name:** _____

Insurance Policy/ID #: _____ **Group #:** _____

Subscriber's Employer: _____**Subscriber D.O.B.:** _____

***Secondary Insurance:** _____ **Subscriber Name:** _____

Insurance Policy/ID #: _____ **Group #:** _____

Subscriber's Employer: _____**Subscriber D.O.B.:** _____

EMERGENCY CONTACT INFORMATION

In Case of Emergency Please Notify: _____

Relationship: _____ **Home #:** _____ **Cell #:** _____

PATIENT PREFERENCE REGARDING APPOINTMENT REMINDER

Time of Day to Reach You: **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Preferred Phone #:** _____

AUTHORIZATION

I request that payment of authorized medical benefits be made directly to either Sanjeev K Goswami, M.D. Inc., Miroslav Djokic, M.D. Inc., Josebelo Chong, M.D. Inc., Mandeep Singh, M.D. Inc., or Abdelghani Pulmonary Associates, for services rendered by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agencies any medical information necessary to determine these benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of any information needed to process the claims with my insurance company and/or to release medical records on my behalf to attorneys or other physicians who may consult on my case. I also understand that I am responsible for any co-payments, deductibles, and non-covered services at the time of the office visit. Rebilling fees will incur on past due accounts.

I certify that the information on this form is true and correct.

Signature: _____ **Date:** _____

Parent or Legal Guardian: _____

HIPAA AGREEMENT

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Stockton Pulmonary Doctors Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

HIPAA Notice of Privacy Practices

Effective as of March/1/2010

Stockton Pulmonary Doctors
1801 E March Lane, Suite C300
Stockton, CA 95210
(209) 464-6422

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.